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MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

HEARINGS

BEFORE THE

TASK FORCE ON HEALTH

OF THE

COMMITTEE ON THE BUDGET

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

MONDAY, SEPTEMBER 30, 1985

House of Representatives,
Task Force on Health,
Committee on the Budget,
Washington, DC.

The task force met, pursuant to notice, at 1:10 o'clock, in room 210, Cannon House Office Building, Hon. Martin Frost (chairman of the task force) presiding.

Mr. Frost. Good afternoon, and welcome to this hearing of the House Budget Committee Task Force on Health.

I would like to begin by thanking all of those present for being here this afternoon and for participating in this hearing. This is the first in a series of three hearings that will be held by the Health Task Force on the Medicare Program. Future hearings will be held on October 7 and October 21. All hearings will take place here in the Budget Committee hearing room.

The subject of this series of hearings is the Medicare Program. Medicare is a nationwide, federally funded health insurance program which provides health coverage for about 31 million aged and disabled Americans.

Medicare spending has increased rapidly during the last few years. In fiscal year 1977, Medicare outlays totaled $19.3 billion. By 1982, outlays for the Medicare Program had climbed to $46.6 billion. The outlay figure for fiscal year 1986 is projected at $69.2 billion.

While the rising cost of the program was, in itself, cause for concern, the financial condition of the hospital insurance trust fund, which pays for the hospital inpatient part of Medicare worsened to the point where it was feared that the trust fund would be depleted.

To contain the program's rising costs and to help ensure its future financial stability, Congress established a new Medicare reimbursement plan for hospitals that became known as the prospective payment system. This change was included as part of the Social Security Amendments of 1983. This new prospective payment system, which pays hospitals at a fixed, predetermined rate for each allowable Medicare case, was a major departure from the past practice of reimbursing hospitals on the basis of actual costs they incurred for treating Medicare patients. By limiting the amount that Medicare would reimburse for treatment, it was hoped that program costs would be contained.

Although its new reimbursement plan is still in the process of being implemented, Medicare continues to be a prime target of deficit reduction efforts. In its 1986 budget, the Reagan administration started deep cuts in the Medicare Program. Congress achieved some Medicare savings when it passed its budget resolution for 1986.

Medicare outlays were reduced by $2.5 billion for 1986, with 3-year outlay savings projected to be $11 billion. It is likely, though, that the administration will seek additional Medicare cuts in next year's budget submission to Congress.

In dealing with future budget requests for the Medicare Program, Congress needs to have a full understanding of the effective changes in law implemented in the past years and proposals for additional changes we may face in the immediate future.

It is the purpose of these hearings to help in this education process, so that informed budget decisions on Medicare can be made. Some of the issues that these hearings will address include:

Has the prospective payment system slowed the rate of increase in the Medicare Program's costs?

What has been the impact of the prospective payment system on hospitals and other health providers?

What has been the impact of the prospective payment system on the quality of care provided to Medicare beneficiaries?

Can additional savings be found in the Medicare Program without adversely affecting beneficiaries, and should the prospective payment system be broadened to include physicians' fees?

Over the course of the next few weeks, we will be hearing from a variety of witnesses who have been asked to address these questions and make suggestions for improving the current system. I know that those of us on the Health Task Force will greatly benefit from their views.

I believe that the information obtained from these hearings will enable the members of this task force to make recommendations to the Budget Committee for the Medicare function, consistent with the deficit reduction effort, while ensuring that Medicare remains financially sound and able to meet the health care needs of millions of Americans.

We have with us today a distinguished group of witnesses. The chairman of the Energy and Commerce Subcommittee on Health and the Environment, Hon. Henry Waxman, who is with us now, will open with his testimony. We will then hear from Dr. Rudolph Penner, Director of the Congressional Budget Office. Following Dr. Penner will be C. McClain Haddow, Acting Administrator of the Health Care Financing Administration. HCFA is part of the Department of Health and Human Services and is responsible for administering the health care programs.

Finally, we will conclude today's hearing with testimony from Dr. Donald Young, Executive Director of the Prospective Payment Assessment Commission. The Commission is charged with monitoring the implementation of the prospective payment system.

I look forward to hearing from our witnesses, and I thank each of you for coming today. At this point, we will hear from my colleague, the highly respected Congressman from California.

STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE ENERGY AND COMMERCE COMMITTEE

Mr. **Waxman**. Thank you very much, Mr. Chairman, for this opportunity to testify here today. I appreciate your interest in the impact of the Medicare prospective payment system on program beneficiaries, hospitals, and the health care delivery system as a whole.

The Committee on Ways and Means, which has substantive jurisdiction over the hospital component of Medicare, is in a better position to provide you with the details on the implementation of PPS. I know that Mr. Stark is committed to improving Medicare and has been a forceful advocate for program beneficiaries. I look forward to continuing to work closely with him on reforming the program.

Before turning to the PPS issue, let me make one general observation about Medicare and the budget process. Since 1980, legislative changes in Medicare have been driven almost exclusively by budget reconciliation instructions. The only exception which comes to mind is the Medicare/Medicaid fraud and abuse bill passed by the House earlier this year.

I believe it is a serious mistake for Congress to continue to make changes in Medicare simply to meet budgetary requirements that have nothing to do with the program itself. So far we have been able to comply with the budget instructions without doing too much damage to the program, but I believe that we have reached a point where further reconciliation instructions for large savings will seriously harm program beneficiaries and many of the providers that serve them.

For Democrats, it is particularly inexcusable to distort Medicare policy in order to reduce Mr. Reagan's ballooning deficit. Even the Senate Republicans are beginning to acknowledge publicly that the whole point of the administration's mammoth deficits is to denationalize the financing of public services, to paraphrase Senator Durenberger.

Why should we play into Reagan's hands by continuing to slash Medicare?

Now, as to Medicare PPS. In my view, PPS appears to be having a generally salutary effect on the hospital sector. Inpatient lengths of stay have been reduced by more than was anticipated, and hospital admissions have unexpectedly been reduced as well. As a result, patient days have been substantially reduced, hospitals are being operated in a more cost-conscious manner, and savings are being achieved for Medicare and for society as a whole.

I want to emphasize, however, that it is still too early to draw any final conclusions about the Medicare diagnosis related group [DRG] methodology. The data are simply not yet in.

Although Medicare began to implement PPS for some hospitals in October 1983, many hospitals have only recently completed their first year under PPS. Even for those hospitals that went onto PPS early, data are still sketchy about the effects which the new payment methodology is having on patients, on hospitals, and on the cost of the Medicare Program. It will be some time before we are able to make informed judgments on whether PPS is impairing the quality of care, impeding access to care, or stifling technological innovation.

Preliminary reports from GAO and other sources indicate that the incentives created by PPS may be leading some hospitals to discharge Medicare patients prematurely. We are, of course, following this with great concern. From the budget standpoint, it is essential that you recognize that the tighter we are forced to squeeze PPS payments, the greater the incentives to shortchange those whom the program is designed to protect.

Please do not misunderstand me. I am not arguing for the status quo. Refinements in the Medicare payment system are and always will be in order, but these adjustments must be thoughtful, well-grounded improvements as represented by the recommendations of the Prospective Payment Assessment Commission and the amendments recently reported by the Ways and Means Committee.

Meat cleaver strategies, such as across-the-board freezes and gross reductions in payment levels, are simply incompatible with intelligent Medicare policy. We cannot freeze the populace from getting older or from getting sick. We cannot freeze the cost of living for hospital workers, and we cannot freeze advances in medical science and technology.

I would urge you to resist the temptation to score large budget savings by continuing to manipulate DRG payment rates. The consequences for the quality and accessibility at many institutions will be profound.

As PPS has made abundantly clear, hospitals are not all alike. Rather, they vary considerably in their size, location, and composition, in their governing structures, in their access to and use of resources, and most importantly in their individual missions and in the populations they serve. Our Medicare payment methodology has to recognize these differences and the effects they have on the cost of delivering care.

We must penalize inefficiency wherever it can be identified, but we should not assume that higher than average costs necessarily imply inefficiency. Public hospitals and other hospitals serving large numbers of indigent patients have a special mission and special needs. Teaching hospitals provide the training and innovation that fulfill our expectations for excellence in medical care. Rural hospitals provide access to care that might otherwise be unattainable.

If we are to meet our national health policy goals, the Medicare system will have to accommodate these special needs and others as well. The work that Mr. Stark and the Ways and Means Committee have done in fashioning an adjustment for hospitals that serve a disproportionate share of Medicare and low-income patients is an excellent example of the kinds of fine tuning that will be necessary.

I am not suggesting that there is no room for further savings in the hospital sector and the health care system generally. Of course there is. But as the Federal Government looks for savings, it should do so in targeted and coordinated strategies that promote a more efficient use of resources, rather than arbitrary restraints on expenditures.

We need to instill better informed and, if necessary, more closely monitored use of sophisticated technology. We need to promote greater consensus and adherence to recognized standards of appropriate diagnostic and therapeutic practice patterns. We need to reform physician payment rules and promote the proper mix of physician specialties and subspecialties. We need to put greater emphasis on prevention, rather than depending solely on curative services.

Mr. Chairman, these are the concerns that we would raise with respect to the prospective payment system and with respect to the role of the Budget Committee in fashioning the policy that has, for the last several years, dictated health policy in Medicare.

I am pleased that you are holding this hearing and look forward to working with you.

I'll be happy to answer any questions you might have.

[The prepared statement of Mr. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

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Preliminary reports from GAO and other sources indicate that the incentives created by PPS may be leading some hospitals to discharge Medicare patients prematurely. We are, of course, following this with great concern. From the budget standpoint, it is essential that you recognize that the tighter we are forced to squeeze PPS payments, the greater the incentives to shortchange those whom the program is designed to protect.

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I would urge you to resist the temptation to score large budget savings by continuing to manipulate DRG payment rates. The consequences for the quality and accessibility of care at many institutions will be profound.

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If we are to meet our national health policy goals, the Medicare PPS system will have to accommodate these special needs, and others as well. The work that Mr. Stark and the Ways and Means Committee have done in fashioning an adjustment for hospitals that serve a disproportionate share of Medicare and low-income patients is an excellent example of the kinds of fine-tuning that will be necessary.

I am not suggesting that there is no room for further savings in the hospital sector, or in the health care system generally. Of course there is. But as the Federal government looks for savings, it should do so in targeted and coordinated strategies that promote a more efficient use of resources, rather than arbitrary restraints on expenditures.

We need to instill better-informed and, if necessary, more closely monitored use of sophisticated technology.

We need to promote greater consensus and adherence to recognized standards of appropriate diagnostic and therapeutic practice patterns. We need to reform physician payment rules and promote the proper mix of physician specialties and subspecialties.

We need to put greater emphasis on prevention, rather than depending solely on curative care.

I intend to continue working for these reforms.

Before closing, I want to bring to the attention of the Task Force what I believe to be the most serious health policy problem confronting the Congress: the increasing number of poor and working poor Americans who have no public or private health insurance, and their increasing difficulty in getting basic health care.

The health care industry is becoming increasingly competitive. Hospitals and physicians are scrambling to retain their existing market share and to attract new paying patients. Many of them are also scrambling to avoid non-paying patients.

Unfortunately, there are between 28 and 32 million people in this country who have no public or private insurance coverage. About one-third of these are poor or near poor. Without public or private coverage, and with no resources of their own, the poor uninsured are finding it more and more difficult to get needed hospital care. From all the reports I am getting, the dumping of uninsured patients—even in emergency cases—is on the increase.

Medicare PPS did not cause this problem, and Medicare PPS cannot, by itself, solve it. But Medicare is part of the problem. It places strong financial incentives on hospitals not to serve those who are unable to pay—and it does not recognize the costs of treating indigent patients who are not Medicare beneficiaries.

If we are to keep our self-respect as a compassionate and civilized nation, we cannot continue to ignore this problem.

And if we are going to address this problem in a serious way, then additional resources will be required. Not just private. Not just local. And not just State. But Federal as well.

Thank you again for inviting me this morning. I would be pleased to answer any questions.

Mr. FROST. I particularly appreciate your testimony, Mr. Waxman, because as you know, during the deliberations on the budget this year, the Budget Committee was in touch with you and Mr. Stark, trying to solicit your views. Your views are very important to the committee. We were not always in agreement, but your views are critical, because you hold a very important position and are very knowledgeable in this area.

I would like to ask you one or two specific things. You mentioned disproportionate share for hospitals that treat a disproportionate share of low-income and Medicare patients. We are going to have some testimony later today from Mr. Haddow, the Acting Administrator of the Health Care Financing Administration, in which he says that it is premature to have a disproportionate share adjustment.

As you know, and as you referred in your testimony, the Ways and Means Committee did make a recommendation in their reconciliation language in their reconciliation bill on this subject. Do you feel that we have enough data to be able to come up with a formula, a disproportionate share formula right now, or is Mr. Haddow correct that right now we are premature in this area?

Mr. WAXMAN. Let me give you some background on the problem.

When the DRG system was adopted by the Congress as part of the Social Security Amendments of 1983 and we set in motion the transition to the new system, we said to the Department, "We want a recognition of the disproportionate share of low-income patients that some hospitals will be treating and to have the Department deal with the special concerns of those institutions."

Well, they just ignored us completely. And now Congress, I believe, is forced to act. I think we have enough information to justify acting.

I don't know what is premature, unless the Department would like to wait to see if these hospitals actually go out of business and are unable to treat these indigent patients unless we provide some special recognition of their mission.

Mr. FROST. What Mr. Haddow's statement provides, Mr. Waxman, and I'm quoting from it:

> We believe that making such an adjustment is premature at this time, because of the unreliability of available data. The relationship between Medicare costs and low-income patients is still not well understood.

Mr. WAXMAN. It's ironic to hear the Department talk about inadequate data when they've come in with recommendations to freeze payments on DRG's and other health care services and to make other adjustments before we have the data. They recommended an extension of the physician freeze, which we were forced to go along with, and which I find quite odious, without knowing whether the current physician freeze has even saved us money.

So if they are willing without sufficient data, to know all the answers and tell us to make adjustments, which may well hurt the system, we ought to be willing to make adjustments with the data that is available now to help those hospitals that are going to be left holding the bag because they have a disproportionate number of low-income patients. And if they don't get some recognition of the role they play in the DRG reimbursement system, they are going to be very hard put to continue to play that role, and I don't know who will play that role if they're not around to take care of those low-income patients.

Mr. **Frost**. One other question. As you know, the reconciliation bill provides for a 1-year pause in transition to the national DRG rates. Do you think that is advisable at this point?

Mr. **Waxman**. I supported that. I supported the legislation that was originally introduced by Congressman Matsui to accomplish that result, and I am pleased that it is in the reconciliation proposal.

It seems to me that we ought to take a breather for that year period and see how this DRG system is working. I don't think the goal of Congress is to reward some hospitals and punish others without rewarding efficiency and penalizing inefficiency.

But the facts of life seem to be that there are some hospitals that are going to be forced to suffer the consequences of a DRG system transition, not because of more efficiency, but based on the fact that they are located in one part of the country as opposed to another. That's not a goal that we ought to be furthering. We ought to stop this thing, slow it down for a year, get a chance to review it, make some fine-tuning adjustments after we have the data that will allow us to make the decisions that we need to make.

Mr. **Frost**. I would just point out one other thing, and then we do have Dr. Penner who is scheduled to testify next.

I think if you have a chance to look at Dr. Penner's statement, you will find some interesting support for one of the statements that you've made in terms of—not using Medicare to reduce the budget deficit. Dr. Penner has detailed what has happened with the hospital insurance trust fund because of the changes that we have made, and, in fact, the hospital insurance trust fund now is in reasonable shape, at least—I'm going to pursue this matter with him when he does testify, but he has some interesting statistics in terms of where we are or how much surplus there is in that fund and the changes that have been made in the past few years.

I assume from your testimony that you feel that the changes on part A so far have been sufficient, and you would not like us to make any additional changes on part A?

Mr. **Waxman**. You're talking about the changes being proposed by the Ways and Means Committee?

Mr. **Frost**. Beyond that. I'm talking about for the next year, because one of the purposes of this hearing is to look at things that we may face in fiscal year 1987, because, as you know, we start the budget process very soon around here. January and February, we will be looking at the 1987 budget, and perhaps the administration will have some additional proposals in that area.

Mr. **Waxman**. We set up the Prospective Payment Assessment Commission to advise us of changes that group thinks are appropriate as it watches the DRG system going into effect. I thought that we should have gone along, and I still think we should go along, with its recommendations to increase the reimbursement rate for hospitals.

Mr. **Frost**. Which we did not do.

Mr. **Waxman**. Which we did not do, and which the Senate ignored even further. I think it's a mistake. I understand that we have to come up with dollar savings in the Medicare Program as part of the budget process, but I am disturbed by using the budgetary process to make what may turn out to be bad health care policy. I'm disturbed by it.

You have Dave Stockman on television yesterday talking about how we have this enormous deficit, which he considers to be a time bomb, a potential tragedy. He lays the blame on the fact that we need to raise taxes, to reverse the tax bill that was passed in 1981 giving tax breaks, and to cut back spending, particularly the military. It seems to me we should use the health care program for the elderly as the way of trying to bring some money into deficit reduction especially since it will not even close up the deficit, but only to make a slight dent in it.

I think we're making bad decisions under the budgetary process, and we are going to regret those decisions, and most of those bad decisions in the health area unfortunately come back to haunt us and cost us more money later on.

One of the concerns that I've had for the last 4 or 5 years, is that we have been asked to squeeze down on health expenditures for a momentary savings in the budget, that I think probably are lost to people and for their medical care, either access or quality, which I think are going to be more expensive from a fiscal and economic point of view as well.

Mr. **Frost**. Thank you very much for appearing, Mr. Waxman. Your testimony has been good as always, and we look forward to working very closely with you during the next budgetary cycle. We will want to hear from you early and hear from you often.

Mr. **Waxman**. I appreciate the cooperation we have always had from the members of the Budget Committee in looking at some of these hard choices to make.

We recognize the attempt by you, particularly, on the Budget Committee to be sensitive to health policy concerns, and we look forward to talking to you further. I hope next year you listen to all of our recommendations. [Laughter.]

Mr. **Frost**. Thank you very much.

Our next witness is Dr. Rudolph Penner, Director of the Congressional Budget Office.

Dr. Penner, it is always a pleasure to have you before the Budget Committee. We look forward to your testimony.

STATEMENT OF RUDOLPH G. PENNER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY STEVEN SHEINGOLD, PRINCIPAL ANALYST

Mr. **Penner**. Thank you very much, Mr. Chairman. It's a pleasure to be here. I would like to introduce Steven Sheingold beside me here. He is one of the Congressional Budget Office's [CBO] experts on the Medicare Program.

Medicare's prospective payment system [PPS] for in-patient hospital care is thought by many observers to be this decade's most significant development in all U.S. health care financing policy. By changing the basis of Medicare's payments from whatever costs a particular hospital incurs to a schedule of preset payments per admission, the system rewards hospitals that treat patients at low costs and penalizes those with high costs. Remaining policy issues within the PPS involve both adjustments to fine-tune the system and decisions about how the gains from improved efficiency are to be shared between the hospitals and the Federal Government.

My testimony today considers three main topics: The objectives and operations of Medicare's PPS; the outlook for Medicare's hospital insurance trust fund; and some possible further changes in the PPS.

Although my remarks focus in particular on the PPS, several other issues may have important implications for Federal health policy decisions.

Outlays under Medicare's supplementary medical insurance [SMI] trust fund continue to grow rapidly, largely because its current system of reimbursing physicians encourages higher fees and more treatment. The Congress may wish to turn next to this area. Also, because public and private insurers are lowering reimbursement rates for the care of insured patients, hospitals may encounter increasing difficulty in financing charity care. If, as a result, access to care for the uninsured and underinsured diminishes, pressure for added Federal spending could mount. Finally, the aging of the population will increase financial pressure on the Federal Government, not only through Medicare, but also for a modified system of financing long-term care.

I raise these points by way of caution: While Federal health outlays are likely to be held down by the PPS, other factors operating in the opposite direction may make budgetary choices regarding Federal health policy extremely difficult.

Mr. Chairman, the next section of my testimony describes the history and the structure of the PPS, and I won't go into that in any detail here. As I already noted, that system sets up a structure of fees, or rates, related to the nature of the illness being treated. There are 468 categories—the diagnosis-related groups, or DRG's—and there is a 3-year transition from hospital-specific reimbursement levels to these national rates.

Proceeding to the status of the HI trust fund, while the balance of that trust fund is a useful accounting device for telling us how we are doing relative to earlier expectations, it isn't a very good measure of the economic burden imposed by hospital insurance. Looking at total outlays is better for that purpose.

Over the next 5 years, outlays are expected to grow at a greater than 10 percent rate, whereas in our projections for the economy, the gross national product increases at something less than 8 percent. Consequently, hospital insurance will continue to be a growing burden in the sense that more and more of our national income will be devoted to it.

Nevertheless, the status of the trust fund, as you mentioned earlier, is much better than we expected it would be a few years ago, and this year's legislation would improve that status even further.

The status has improved partly because there has been a noticeable slowdown in the rate of growth of admissions; also the length of stay has shortened. If you look at figures 1 and 2 on page 9 of my testimony, you can see those developments.

I would like to sit here and say that these changes are because of the wondrous things done by PPS, but unfortunately I cannot. Those developments started before the prospective payment system was introduced.

Let me turn now to various options that have been discussed for changing the PPS. The Congress has been considering a number of them, and they reflect either concerns about the system's design or perceived opportunities to realize additional budgetary savings. Some modifications are likely to be adopted this year, and others may be the subject of debate in the next several years.

The rest of my statement concentrates on possible changes in five areas: The so-called update factor—that is, the degree to which we increase the rates under the DRG system; the speed of transition to national payment rates, which I mentioned before; payments to hospitals that serve disproportionately large numbers of low-income patients; the indirect teaching adjustment; and the expansion of PPS to cover other hospital costs.

The notion underlying the PPS is that the national payment rate is adjusted only for unavoidable cost differences—those thought to be beyond any one hospital's direct control. The system now recognizes these differences by applying separate rates for urban and rural areas, by adjusting the rates for local wage differences, and by adjusting rates for teaching hospitals to reflect their higher costs. Many of the options that CBO has analyzed have been proposed in the belief that there are other unavoidable cost differences that are not now taken into account, or that current adjustments could be refined.

Important considerations in assessing these options are the effects on Medicare's aggregate payments to hospitals, the distribution of payments among types of hospitals, the incentives for hospitals and physicians, beneficiaries' access to care, and the quality of care available. The last issue—quality of care—is a particularly difficult effect to quantify.

Decisions about one dimension can interact with another. For example, whether an option is designed to increase, lower, or hold Federal spending constant could affect the distribution of payments among hospitals. Raising payments to one type of hospital could be financed without increasing budgetary outlays, for instance, but only by lowering payments for some or all other hospitals. Similarly, decisions about the distribution of payments could affect the incentives facing hospitals. Changing payments related to some activity—for example, graduate medical education—would probably affect hospitals' decisions about the size of residency programs, indeed whether to undertake them at all. Finally, concern is widespread that, if aggregate payments are lowered sufficiently, hospitals would be discouraged from admitting Medicare patients or would change treatment courses in ways that would lower the quality of their care.

Let me briefly summarize what we say in the complete statement about these various options.

First, the update factor could be limited legislatively each year in a way that would save money. This year, in proposed legislation, the Congress is contemplating overruling the Secretary of HHS. She suggests a freeze of those rates. The Congress would raise them a little bit, but far less than we assumed they would be raised in making our baseline estimates. Therefore, there would be substantial budget savings, $5.2 or $5.9 billion, depending on whose approach you look at.

Obviously, in making that decision, the Congress has to walk a narrow line between different kinds of risks. On the one hand, the budget situation suggests that we do have to save money where possible. On the other, the quality of care should not go down. As I said before, that is an extremely difficult thing to measure.

Another issue involves the speed at which we move toward these national payment rates. There is some concern that there are legitimate cost differences among hospitals that are not reflected by the current structure of payment rates.

Some specialists suggest that we should delay the transition while we fine tune the system to take account of such costs; others say that we should permanently blend hospital-specific and national rates. Again, there are risks on each side. Any delay or permanent blending of the system would reduce incentives for pursuing efficiency. On the other hand, the current approach and the speed at which we make the transition could result in some inequities among hospitals.

A third option is to raise the PPS rates for hospitals that serve a disproportionate share of low-income people. These people tend to suffer more severe illnesses within each category and, therefore, are more expensive to treat. The question is, Should an adjustment be made to offset that?

Now this is mainly a problem, as we see it from studying the data, for large urban hospitals, and it particularly becomes a problem when the share of low-income patients exceeds 15 percent.

Any consideration of the disproportionate share issue should probably look at the so-called teaching adjustment at the same time. Currently, the teaching adjustment is thought to be a proxy, in part, not only for added teaching costs, but also for the fact that teaching hospitals tend to be those that serve a large proportion of low-income people.

Looking at the teaching adjustment in the abstract, our research indicates that it could be cut substantially, and cuts have indeed been included in bills reported by the Ways and Means Committee and the Senate Finance Committee. If one looks at the longer run, even further cuts might be possible, especially if separate adjustments for other cost factors thought to be related to teaching were made.

Some people have suggested expanding PPS. It does not now cover capital costs. Those capital costs are still reimbursed as they occur, and there is concern about the efficiency of handling them that way. They could possibly be handled prospectively, for example, by some proportionate increase in the DRG's.

Similarly, with regard to the direct costs of medical education, which are now compensated for as they occur, one could instead look at a system of fees that pay so much for each person educated and perhaps different amounts for different specialties, and so on.

There are many other related issues, Mr. Chairman, that I could go into. As you know, some hospitals are now exempted from the PPS. They might be brought in. One could bring in outpatient services and skilled nursing facilities.

The basic point, I think, is that Medicare's PPS represents a major step toward developing the mechanisms for controlling hospital costs and encouraging efficiency, but it is an extremely complicated system. As we learn more about the factors influencing hospitals' costs, the Congress is refining the system and seems likely to continue these efforts for some years hence. Moreover, the rapid pace of change in the health care system and the aging of the population, to name only two of many influences, suggests that Federal health policy will remain an important budgetary issue for the future.

Thank you very much, Mr. Chairman.

[Testimony resumes on p. 36.]

[The prepared statement of Mr. Penner follows:]

PREPARED STATEMENT OF RUDOLPH G. PENNER

Mr. Chairman, Medicare's Prospective Payment System (PPS) for inpatient hospital care is thought by many observers to be this decade's most significant development in all U.S. health-care financing policy. By changing the basis of Medicare's payment from whatever costs a particular hospital incurs to a schedule of pre-set payments per admission, the system rewards hospitals that treat patients at low cost and penalizes those with high costs. Remaining policy issues within the PPS involve both adjustments to fine-tune the system and decisions about how the gains from improved efficiency are to be shared between the hospitals and the federal government.

My testimony today considers three main topics:

- The objectives and operations of Medicare's PPS,
- The outlook for Medicare's Hospital Insurance (HI) trust fund, and
- Some possible further changes in the PPS.

Although my remarks focus in particular on the PPS, several other issues may have important implications for federal health policy decisions. Outlays under Medicare's Supplementary Medical Insurance trust fund continue to grow rapidly, largely because its current system of reimbursing physicians encourages higher fees and more treatment. The Congress may wish to turn next to this area. Also, because public and private insurers are lowering reimbursement rates for the care of insured patients, hospitals may encounter increasing difficulty in financing charity care. If, as a result, access to care for the uninsured and underinsured diminishes, pressure for added federal spending could mount. Finally, the aging of the population will increase financial pressure on the federal government, not only through Medicare, but also for a modified system of financing long-term care.

I raise these points by way of caution: while federal health outlays are likely to be held down by the PPS, other factors operating in the opposite direction may make budgetary choices regarding federal health policy extremely difficult.

THE PPS AND ITS FORERUNNER

In passing the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress laid the groundwork for the PPS, introduced as part of the Social Security Amendments of 1983. Both actions were prompted by an unacceptably high rate of growth in Medicare's outlays for hospital costs, which averaged 18 percent a year between 1975 and 1982, or 8 percent a year above general price inflation. Moreover, concern was widespread that the cost-based reimbursement system now superseded by the PPS did not encourage economic efficiency, and that it was not producing health improvements in proportion to federal spending. For both actions, the Congress's obejctive was to lower the rate of growth of Medicare's payments to hospitals, while promoting the provision of high-quality health care.

As a first step, TEFRA limited the growth of hospital reimbursement per admission to the rise in prices for hospital goods and services, plus 1 percent for other factors. In the first two years of the PPS, Medicare payments to the hospital industry as a whole were designed to equal the aggregate outlays that would have occurred under TEFRA, but in the third year (fiscal year 1986) the Secretary of Health and Human Services (HHS) was given discretion over the rates.

Under the PPS, a fixed payment rate is set in advance for each of 468 categories known as diagnosis-related groups (DRGs), which were designed to reflect the value of resources used to detect and treat different types of conditions. During a three-year transition, the prospective amounts are based on a combination of hospital-specific, regional, and national rates. 1/ The hospital-specific portion is based on each hospital's own pre-PPS costs. Eventually, the system will be based on national rates only, calculated separately for urban and rural areas. 2/ Each hospital's rates are also to be adjusted for differences in wage levels among geographic areas, and for the size of an institution's in-hospital training program for physicians.

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1. Some hospital costs and some institutions are exempt from the PPS. Capital-related costs, such as depreciation and interest payments, and the direct costs of graduate medical education programs, continue to be reimbursed on a "reasonable-cost" basis. Moreover, children's hospitals, rehabilitation centers, and psychiatric hospitals are exempt from the PPS.

2. All participating hospitals have now begun their second year under the PPS, meaning that 50 percent of their payments is based on a combination of regional and national rates, while the remainder is hospital-specific. On October 1, 1985, approximately one-fourth of these hospitals will enter their third PPS year, when 75 percent of their payments will be based on regional and national rates. The regional rates will be phased out for all hospitals by fiscal year 1987.

The adjustment for hospitals with approved teaching programs, termed the indirect teaching adjustment, proportionately increases the national and regional rates used to calculate their payments from Medicare. Initially, the adjustment was intended to compensate these hospitals for the increased patient-care costs associated with teaching programs. Later, the estimated adjustment was doubled as an interim step to pay for a variety of other cost-increasing factors associated with large teaching hospitals and not otherwise accounted for by the PPS. These factors include greater severity of illness within DRGs, location in an inner city, and service to a disproportionately large share of low-income patients. As a result of how PPS payments are calculated, the additional payments for teaching hospitals were, in effect, financed by lowering payment rates for all hospitals. Because the rates were calculated separately for the nine Census regions, the reductions during the transition are largest in the areas with the greatest teaching activity. 3/

Beginning in fiscal year 1986, the prospective payment rates can be adjusted annually at the discretion of the Secretary of HHS. This adjustment, known as the "update factor," has two components. The first reflects the change from the preceding year's prices of goods and services purchased by hospitals--often called the hospitals' "market basket." The

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3. Because almost all teaching hospitals are located in urban areas, rural hospitals are essentially unaffected. Once the system is fully phased in, urban hospitals in all regions will receive the same percentage reduction in their PPS rates.

second, called the "discretionary adjustment factor," is intended to reflect technological and scientific advances, productivity change, and improvements in the quality of care. While the cost of the market basket is generally expected to rise, the discretionary factor could be positive or negative. Rates for fiscal year 1985 were raised 5.6 percent above the 1984 level. Though, in 1984, the Congress limited the update factor for 1986 to no more than the increase in the cost of the market basket plus one-quarter of a percentage point, Secretary Heckler has determined that no increase is necessary.

THE OUTLOOK FOR THE HOSPITAL INSURANCE TRUST FUND

The Congressional Budget Office's (CBO) projections of the status of the HI trust fund show it to be financially sound through the Congressional planning period of five years; year-end balances would rise over the 1986-1990 projection period from $30 billion to $42 billion (see Table 1). These projections assume that annual increases in PPS rates equal the market basket increase plus one-quarter of one percent. Moreover, if some of this year's proposals for modifying the PPS--such as those reported by the House Committee on Ways and Means--are enacted, the HI trust fund's financial soundness would be reinforced.

It should be emphasized, however, that the burden that Medicare places on the economy is better measured by the level of outlays than by the status of the trust fund. Between 1985 and 1990, hospital insurance outlays are expected to grow by over 10 percent a year, a far greater rate than the assumed 7.8 percent annual rate of growth of our gross national product. Consequently, despite recent reforms and the improvement in trust fund balances, hospital insurance will continue to impose an ever-growing burden on the economy.

TABLE 1. BASELINE BUDGET PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND OUTLAYS, INCOME, AND BALANCES: TO FISCAL YEAR 1990

	1986	1987	1988	1989	1990
	In billions of dollars				
Outlays	52	58	64	71	79
Income	62	68a/	67	72	77
Year-End Balance	30	40	43	44	42
	As a percent of outlays				
Balance	57.1	69.3	67.5	61.7	53.0

SOURCE: Congressional Budget Office, September 1985 estimates.

a. This figure reflects repayment from inter-fund borrowing.

Longer-term projections of trust fund balances, however, depend on many difficult assumptions. Outlay will depend on such variables as changes in the rates that Medicare will pay hospitals, the number of beneficiaries, admission rates, complexity of diagnoses, and other factors. Since Medicare's rates for inpatient care are under the Secretary's discretion or can be legislated, they are extremely difficult to forecast. To illustrate, this year's action by the Ways and Means Committee to limit the increase in

PPS rates to 1 percent would change the 1990 trust fund balance (shown in Table 1) from 53 percent to 68 percent, thereby reversing the slight decline shown for the 1986-1990 period. Improving health status of the elderly population might reduce, or at least postpone trust fund outlays. On the other hand, assigning patients to DRGs is sometimes subject to uncertainty. In a case in which a patient might legitimately be classified in either of two DRGs, the hospital has an interest in selecting the higher-priced one. The extent to which the complexity of diagnoses has grown and might continue to grow would increase outlays, though by how much is difficult to estimate. Finally, forecasting changes in medical technology and their implications for spending is very difficult.

On the income side, revenues flow into the trust fund mainly through payroll taxes, which depend on wage rates and employment levels. Macroeconomic forecasting in this area is particularly subject to uncertainty. Income projections are more sensitive to employment forecasts than to forecasts of the general price level. A change in prices, which is a principal determinant of wage changes, does not greatly affect projected trust fund balances, since a change in prices tends to affect both revenues and outlays in the same direction.

CBO's last analysis of the long-term prospects for the HI trust fund assumes that the PPS rates would rise by the increase in the cost of the market basket, plus one percentage point for 1987 and beyond. The analysis shows that the fund would remain financially viable until at least the mid-1990s. 4/ Since CBO's earlier analysis, added data suggest that the period of financial viability may be longer.

In 1984, for example, after rising each year since the inception of Medicare, hospital admissions of elderly patients fell (see Figure 1). 5/ Since Medicare's payments are based on admissions, future outlays will be reduced, provided that this drop in admission rates is not a short-run aberration, and that the complexity of admissions does not increase sufficiently to offset it. Prospects for the trust fund would thus improve.

It is not clear, however, that the drop in admissions is in any way attributable to the PPS, making its duration all the more uncertain. In 1983, most analysts predicted that the incentives under the PPS would stimulate admissions. Moreover, admissions of nonelderly patients began to drop in 1981--falling from 27 million to 25 million (more than 7 percent) by 1984 (also shown in Figure 1). Because this drop for the nonelderly began well in advance of the legislation that created the PPS, it--and therefore the decline for the elderly--may be largely caused by other forces affecting the hospital industry.

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4. Statement of Eric A. Hanushek, Deputy Director, Congressional Budget Office, before the House Committee on Ways and Means, Subcommittee on Health, September 13, 1984.

5. All statistics in this section are based on data provided by the American Hospital Association from its panel survey of U.S. hospitals.

Figure 1. Hospital Admissions of Elderly and Nonelderly Patients, Fiscal Years 1967-1984

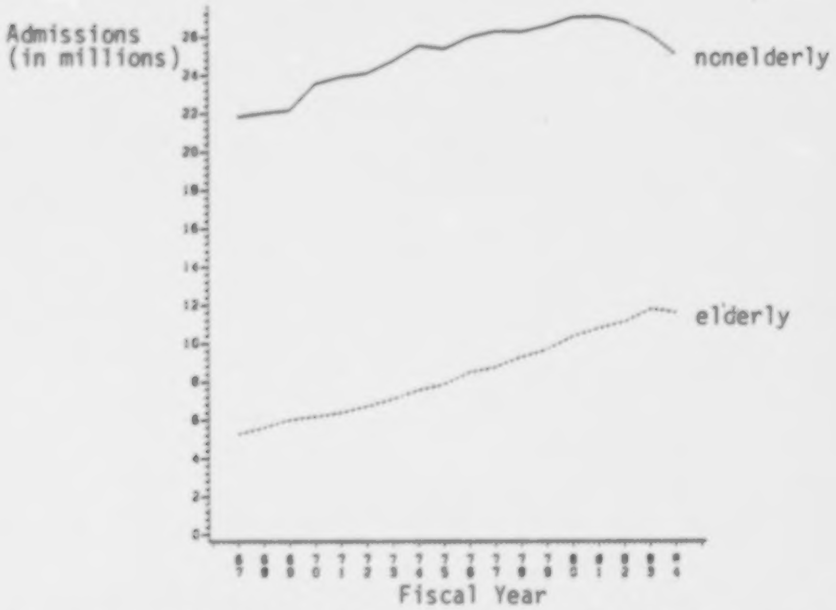
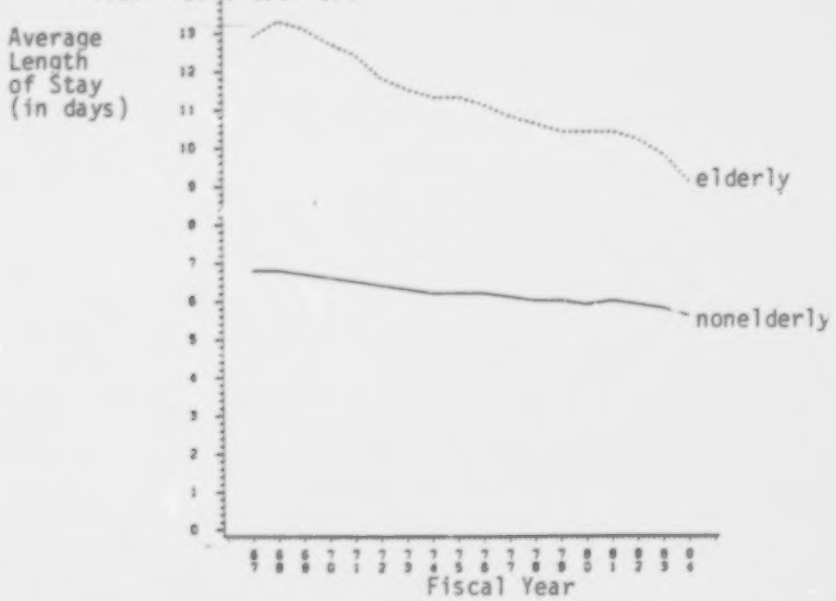


Figure 2. Average Length of Stay for Elderly and Nonelderly Patients, Fiscal Years 1967-1984



SOURCE: Congressional Budget Office from American Hospital Association Panel Survey.

In contrast, a longstanding trend toward declining length of hospital stays by elderly patients accelerated when the PPS began--falling from 9.8 days to 9.1 days between 1983 and 1984 (shown in Figure 2). The PPS carries strong incentives for cutting costs, including shorter stays. Again, however, no conclusions about cause and effect are because a corresponding acceleration of the trend toward shorter stays among the nonelderly began in 1981, with a fall from 6.0 days to 5.6 days over a three year period.

Whatever its cause, the shortening of lengths of stay for the elderly has no immediate implication for Medicare outlays, because the PPS does not pay by the day. In the longer run, if shorter stays allowed hospitals to cut back on numbers of staff and beds, the opportunity for more budgetary savings might follow. To date, however, the aggregate data for all inpatient activities (not just Medicare) suggest that hospitals have not reduced their purchases of goods and services in proportion to the declines in use. For example, while total inpatient days fell by 8 percent between 1983 and 1984, and admissions by 3 percent, numbers of full-time equivalent staff fell by only 1.2 percent and numbers of beds by only 0.6 percent. As a result, the cost per admission rose by 8 percent for 1984, while the cost per day rose by 13 percent.

Despite the fall in hospital use and the rising cost per patient, hospital operating margins--that is, the percentage by which total expenses fall below total revenues--did not decline in 1984. They stood at 5.7 percent for the industry as a whole, up from 5.3 percent in 1983, continuing a trend of rising margins since the early 1970s, when they were about 2 percent. This is not to say that some hospitals are not in financial distress, but--consistent with the original intent of the PPS--the industry as a whole appears to be in good financial health.

OPTIONS FOR CHANGING THE PPS

The Congress is now considering changes to the PPS, reflecting either concerns about the system's design or perceived opportunities to realize additional budgetary savings. Some modifications are likely to be adopted this year, and others may be the subject of debate in the next several years. The remainder of my statement concentrates on possible changes in five areas:

- The update factor;
- The transition to national payment rates;
- Payments to hospitals that serve disproportionately large numbers of low-income patients;
- The indirect teaching adjustment; and
- Expansion of the PPS to cover other hospital costs.

The notion underlying the PPS is that the national payment rate is adjusted only for unavoidable cost differences--those thought to be beyond any one hospital's direct control. The system now recognizes these differences by applying separate rates for urban and rural areas, by adjusting the rates for local wage differences, and by adjusting rates for teaching hospitals to reflect their higher costs. Many of the options CBO has analyzed have been in the belief that there are other unavoidable cost differences that are not now taken into account, or that current adjustments could be refined.

Important considerations in assessing these options are the effects on Medicare's aggregate payments to hospitals, the distribution of payments among types of hospitals, the incentives for hospitals and physicians, beneficiaries' access to care, and the quality of care available. The last issue--quality of care--is a particularly difficult effect to quantify.

Decisions about one dimension can interact with another. For example, whether an option is designed to increase, lower, or hold federal spending constant could affect the distribution of payments among hospitals. Raising payments to one type of hospital could be financed without increasing budgetary outlays, for instance, but only by lowering payments for some or even all other hospitals. Similarly, decisions about the distribution of payments could affect the incentives facing hospitals. Changing payments related to some activities--for example, graduate medical education--would probably affect hospitals' decisions about size of residency programs and indeed, about whether to undertake them at all. Finally, concern is widespread that, if aggregate payments are lowered sufficiently, hospitals would be discouraged from admitting Medicare patients or would change treatment courses in ways that would lower the quality of their care.

The Update Factor

The Congress could legislate the PPS update factor annually, potentially leading to substantial budgetary savings relative to current projections. The CBO baseline projections incorporate the common assumption that PPS rates will rise each year by the growth in the cost of the hospital market basket plus one-fourth of a percentage point--about 5 percent for 1986. Depending on various factors, such as cost-reducing technological advances, the Congress could decide to set the update factor at a lower level. For fiscal year 1986, the House Committee on Ways and Means and the Senate Committee on Finance have proposed to overrule the Secretary of HHS' decision to freeze the PPS rates and instead, to provide a small increase--1 percent and 0.5 percent, respectively. Though these actions would increase outlays relative to the Secretary's decisions, there would be substantial savings relative to the CBO baseline--$5.2 billion to $5.9 billion, respectively, during the next three years.

This approach has drawbacks, however. Consistently setting the update factor below the increase in the cost of the market basket might gradually reduce the quality of care Medicare beneficiaries receive. Hospitals in financial distress, or those that serve predominantly Medicare patients, might be forced to cut back services or even to close. Moreover, high-cost but beneficial advances in treatment might be less available to Medicare patients than to others with private insurance.

The Transition to National Payment Rates

Another important issue for the PPS is whether the transition to national urban and rural rates should continue as now scheduled. In particular, many critics have questioned whether these rates are appropriate standards for all hospitals in the system. Individual hospitals' costs have varied considerably in past years, the variations being related to factors such as the size of the hospital, scope of services, region of the country, size of the city, cost of goods and services, and whether there is a teaching program.

Because of concern that current rates do not reflect all legitimate cost differences, proposals have been made to delay the transition for some period, such as one or two years, to allow time for the completion of current research and data collection. In this way, the system could be refined before being fully implemented. Alternatively, the PPS rates could be permanently based on a combination of hospital-specific, regional, and national rates. One proposal would use 50 percent regional rates and 50 percent national rates. Others would blend national and regional, or national and hospital-specific rates on a DRG-specific basis, with the exact proportions depending on the variability of costs within each DRG.

Just as the current transition poses risks, so would any of the alternatives. Delaying the transition, or allowing hospital-specific costs to affect PPS rates permanently, would allow the continuation of more payment to hospitals that had been less efficient in the past than to those that had achieved lower costs. Moreover, these approaches might diminish the incentives for hospitals to reduce costs. Finally, there is no evidence at present that regional rates would be superior to national rates. Althougn there are significant differences in average hospital costs among regions, these may derive from factors that the system was explicitly designed to ignore (such as the practice patterns of physicians) or from factors that are beyond hospitals' control but that might better be handied through specific adjustments to the PPS rates.

A final alternative would be to continue the transition, but to expand the types of areas for which national rates are calculated. For example, a separate rate might be calculated for the largest Metropolitan Statistical Areas (MSAs), which consistently have had higher costs than either other urban areas or rural areas. Alternatively, separate rates might be calculated for central or inner cities that seem to have higher costs than suburban areas within the same MSA. This approach shares the drawback of using regional rates--namely, that some factors should be ignored and that others might better be handled through new or improved adjustments. Moreover, MSA and central city geographic definitions are rather arbitrary and do not necessarily correspond to the appropriate market area for hospitals.

Payments to Hospitals that Serve Disproportionately Large Shares of Low-Income Patients

Concern is widespread that hospitals serving disproportionately large shares of low-income patients (often called "disproportionate share" hospitals) are placed at a disadvantage under the current PPS, which does not directly adjust for the potentially higher costs incurred in treating these patients. Preliminary evidence suggests for instance, that low-income Medicare patients within a given DRG are more severely ill and more costly to treat than are higher-income beneficiaries. In addition, disproportionate share hospitals may incur extra operating and overhead costs in meeting the special needs of both elderly and nonelderly low-income patients. They may, for example, employ additional staff, such as nutritional technicians and language interpreters, or have special departments or facilities, such as social work services, that lead to higher average costs for Medicare patients.

The CBO has found that both a hospital's proportion of elderly patients who have low-incomes, and its proportion of patients of all ages who have low-incomes, are associated with significantly higher costs for treating Medicare beneficiaries. Moreover, these effects tend to occur beyond a threshold proportion of low-income patients, usually at about 15 percent of patients having low-incomes, and are largest for urban hospitals with 100 beds or more. There is little or no increase in costs for small urban or for rural hospitals. 6/

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6. Statement of Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office, before the Committee on Finance, Subcommittee on Health, United States Senate, July 29, 1985.

The cost of a disproportionate share adjustment could be financed in several ways. To avoid double payments, the indirect teaching adjustment could be reduced, since it already includes some allowance for the extra costs of treating low-income patients. Aggregate payments could then be allowed to expand to accommodate the remaining cost of the adjustment. Alternatively, the disproportionate share adjustment could be made without increasing budgetary outlays by reducing DRG payment rates for all hospitals or for particular groups of hospitals. For example, if urban hospitals only were eligible for the disproportionate share adjustment, then only urban rates might be lowered.

Both the House Committee on Ways and Means and the Senate Committee on Finance have proposed adjustments for disproportionate share hospitals. The Ways and Means Committee plan would base the adjustment on the share of a hospitals' patients who have low incomes and increase payments only for urban hospitals with 100 beds or more. The Finance Committee's plan would be based only on the share of elderly patients having low-incomes, and it would be available to both urban and rural hospitals of 100 beds or more. In addition, the latter plan includes an adjustment for small hospitals with exceptionally large shares of low-income elderly patients.

The Indirect Teaching Adjustment

In the short run, the indirect teaching adjustment could be cut substantially while still serving its intended purposes of compensating hospitals for the increased patient-care costs associated with teaching programs and with other factors not directly accounted for by the PPS. The CBO has estimated that an indirect adjustment of 8.4 percent (compared with the current adjustment of 11.59 percent) would be sufficient to take account of all cost factors not already considered in determining PPS rates. This technical correction would reduce payments by $2.3 billion during fiscal years 1986-1988. If a specific disproportionate share adjustment were also legislated, a further reduction in teaching payments would be required to avoid double payment. Both the Ways and Means and the Finance Committee bills would make further reductions--to 8.1 percent and 7.7 percent, respectively--which would be used to offset part of the cost of their disproportionate share proposals.

In the long run, especially if other changes to the DRG rates were enacted, the teaching adjustment might be reduced further. Findings from several ongoing research efforts to measure severity of illness might be used in conjuction with or in place of the DRG classifications. 7/ Moreover, other potential changes, such as separate PPS rates for large MSAs or central cities, would also affect the size of the teaching adjustment. To the extent that these and other changes improved the system's ability to account for systematic cost differences among hospitals, the teaching adjustment might be reduced to between 4 percent and 5 percent. The

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7. See, for example, the articles collected in the 1984 Annual Supplement of the Health Care Financing Review.

resulting savings could either be used to reduce the federal budget deficit or could be redistributed to all hospitals in the form of higher payment rates.

Expansion of the PPS to Cover Other Costs

The two major types of inpatient hospital costs not currently covered under the PPS are those for capital and for expenditures on medical education programs.

Capital. Though the Social Security Amendments of 1983 set up a system of prospective reimbursement for hospitals' operating costs, it did not change the method for reimbursing capital-related costs. Medicare's share of such costs as interest, rent, and depreciation expenses are still paid retrospectively, based on the proportion of costs attributable to Medicare patients in each hospital. These reimbursements for capital expenses account for about 6 percent to 7 percent of Medicare's payments to hospitals--roughly $3 billion to $4 billion in fiscal year 1986. Because of concern that too much has been spent on hospital facilities and equipment, and that the combination of prospective reimbursement for operating costs and retrospective payments for capital expenses provides even greater incentives for investment, the Congress made clear that it intended to consider ways of making capital reimbursement policy conform to the PPS.

One alternative would be to include all capital costs in the DRG rates by increasing each rate by a uniform percentage--based on a national average for the percent of hospital expenditures attributable to capital. The major drawback to this approach is that for any one hospital, expenses are "lumpy"--that is, large projects and expenditures occur infrequently. Therefore, immediate implementation of the uniform add-on might disadvantage those hospitals that have recently made large expenditures, though this effect could be largely offset through hospital borrowing. Another approach would be to include only some capital costs in the DRG rates--such as those for equipment--but continue to pay retrospectively for the costs of constructing and renovating facilities. Though this method would alleviate the problems caused by infrequent expenditures, it would not provide incentives to limit spending on large projects. Finally, capital expenditures could be rationed by establishing statewide limits for such spending, perhaps at a percentage of Medicare's payments to hospitals in a given state. This approach might improve targeting of funds to where the need is greatest, but many critics would oppose the expanded role of government in allocating capital.

Direct Medical Education. Also excluded from PPS since its inception are the direct costs incurred by hospitals for medical education--for example, residents' stipends, faculty salaries, and classroom costs. [8] Interest in modifying the current reimbursement scheme stems from three concerns. First, retrospective cost reimbursement of any function provides no incentive to economize. Second, the growing supply of physicians might call into question federal payments that support adding more to their numbers. Finally, up to half of direct medical education costs consists of items that are shared in common with other activities, so hospitals might increase their revenues by attributing more of the common costs to the education function.

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[8] More than 70 percent of direct medical education expenses reimbursed by Medicare is for graduate training of physicians. The remainder is for training in nursing and the allied health professions.

One way to control Medicare's payments for direct medical education involves either continuing "reasonable cost" reimbursement, but subject to limits or freezes, or moving to a prospectively established total for each hospital's medical education payment or to a prospective rate per-resident. These options would accrue savings relatively slowly, because they could only lower the rate of increase on about 3 percent, or about $1.5 billion, of Medicare's payments to hospitals.

Other approaches would deny or significantly reduce payments for particular groups of residents. These options, having somewhat greater savings potential, could be enacted either separately or in addition to the former type of option. For example, Medicare could pay differentially for residents in various specialties (for example, primary care versus other specialties), at various stages of training (for example, before versus after board certification), or of different backgrounds (for example, graduates of American versus foreign medical schools). In contrast to controls on reimbursements for all residents, however, the effects of the differential payment options on particular groups of residents or hospitals would be correspondingly greater. Finally, if costs for training particular categories of residents were no longer reimbursed, these groups might also be dropped from the intern and resident count on which the indirect teaching adjustment is based. The net result would be increased budgetary savings.

Other Issues

There are many other issues related to prospective payment that the Congress might address. Examples are inclusion of the hospitals currently exempted from the PPS, and control of costs in outpatient settings and skilled nursing facilities. There is not time to discuss these issues today, however.

CONCLUSION

Medicare's PPS represents a major step toward developing the mechanisms for controlling hospital costs and encouraging efficiency, but it is an extremely complicated system. As we learn more about the factors influencing hospitals' costs, the Congress is refining the system and seems likely to continue these efforts for some years hence. Moreover, the rapid pace of change in the health-care system and the aging of the population, to name only two of many influences, suggest that federal health policy will remain an important budgetary issue for the future.

Mr. **Frost**. You have given a very comprehensive statement. I have some specific questions, and then Mr. MacKay has joined us, my colleague on the committee and on the task force. I would like to give him the opportunity to ask you some questions.

I would like to start by going back to the table on page 6 of your testimony regarding the hospital insurance trust fund. I found that very interesting, and I want to make sure that I am clear. I believe I understand you, but I want to make sure.

This table, of course, was based on assumptions prior to the action taken by the Ways and Means Committee, and your testimony talks about even additional savings based on that action. But this table is based on giving the full inflation rate for DRG's. Even with that, your figure for 1986 shows income to the hospital trust fund of $62 billion and outlays of $52 billion. So even before the action we took this year, the hospital trust fund in the unified budget was subsidizing the deficit reduction effort by $10 billion; is that correct?

Mr. **Penner**. Yes, sir, in fiscal year 1986.

Mr. **Frost**. So there was no need, just from a budgetary standpoint in terms of outlays versus income, to make any changes this year to make sure that we would have enough money coming into the trust fund to take care of the outlays, and it was for other reasons that those changes were made.

Mr. **Penner**. Yes, but I think for quite important reasons. Obviously, anything that would reduce the outlays or increase the income of the trust fund allows it to hold more debt that would otherwise be a drain on national savings. So there is a very clear and important effect on the budget deficit.

Mr. **Frost**. But those are larger budgetary questions involving the size of the deficit, rather than whether the trust fund is self-supporting or not.

Mr. **Penner**. That is correct.

Mr. **Frost**. That this part A trust fund operates on the same concept as the Old Age and Survivors' Trust Fund under Social Security, in that this year's income should be enough to pay for this year's outlays, and to the extent that there is not, then you would have to go into reserves from previous years.

So that in looking at this table for 1986, 1987, 1988, and 1989—not for 1990, but again this was prior to this year's action--but for those 4 years, income to the hospital trust fund exceeded projected outlays, so that there was enough money coming in to cover the outlays that were anticipated.

Mr. **Penner**. That is correct. As you can see, the surplus is shrinking rapidly as we go through time. But as you have also suggested, we have not yet taken into account the most recent developments.

Mr. **Frost**. Now in taking into account the action—that is, providing for a 1-percent increase in DRG's, rather than the full inflation rate—the income figures are even better—that is, that the income figure versus outlays improves—and you pointed out in your testimony, reading at the top of page 7:

> To illustrate, this year's action by the Ways and Means Committee to limit the increase in PPS rates to 1 percent would change the 1990 trust fund balance (shown

in table 1) from 53 percent to 68 percent, thereby reversing the slight decline shown for the 1986–1990 period.

So that the action we took this year means that the balance will be improved on through the next 5 years.

Mr. PENNER. That is correct; yes.

Mr. FROST. Now at what point, based on this year's action—and your testimony, I don't believe, addresses this—but based on this year's action, the 1 percent, at what point does the trust fund start to have problems? How far out in the distant future would it have problems, if we took no further action, if next year we granted the full inflation increase for DRG's, rather than freezing it or having a 1-percent increase?

Mr. PENNER. We just have not been able to sort that out yet. We are waiting for the dust to clear between the House and the Senate. We hope to do that analysis soon after finding out what the final legislation is.

Mr. FROST. Well, my concern is that the administration may well come back next year and ask us to freeze DRG's again or to have only a 1-percent increase or a 1.5-percent increase, rather than the full inflation rate for DRG's.

My question to you is, if we were to do something like that, when would the hospital trust fund—in a general sense; I know you can't necessarily be specific with the numbers you have right now—but what year are we talking about in the future would the hospital trust fund have problems, if after this year we grant a full inflation increase for DRG's? Do we have any idea?

Mr. PENNER. Well, needless to say, the farther you go in time, as I point out in my testimony—but did not in my summary of the testimony—the more the uncertainties begin to proliferate about all of these things. So we have been very hesitant to announce a precise date on which the trust fund is expected to go belly-up. But without having done the detailed work, I would guess that you are pushing that date out, perhaps as far as into the 21st century.

Mr. FROST. Into the 21st century, simply by the action we have taken this year.

Mr. PENNER. Also there are these other improvements and, as I say, we do not know of the extent to which those are related to the new PPS.

Mr. FROST. But certainly for the next 4 years, even with the figures you have in your testimony, the Medicare hospital trust fund is subsidizing the effort to reduce the deficit because of the fact that more money is coming into that trust fund than is going out.

Mr. PENNER. Another way to put it is that the trust fund is buying debt that was issued on behalf of financing the rest of the Government. The HI trust fund is paid interest on that debt, so I am not sure I would use the word "subsidize."

Mr. FROST. But there are people in the Congress, not just this task force, who are concerned that the Social Security trust fund, both the old age and survivors' portion, and the hospital insurance portion, are being used to balance the budget or to reduce the deficit, when in fact there are not deficits in the trust fund.

I mean, I hear this from my constituents all the time: Why are we using Social Security? Why are we using the Social Security trust fund that has a surplus in it to help with the deficit reduction effort?

They could understand if the Social Security trust fund or the hospital insurance trust fund were itself running deficit. But, when those trust funds are running a surplus, why are we making even additional cuts to enlarge that surplus? And that is a question that those of us as Members of Congress have to answer every day.

Mr. PENNER. I think it is important to point out that, while those trust funds are in surplus today, we do not expect that situation to continue with regard to Social Security cash benefits. That part of Social Security will be accumulating very large surpluses late in the 1990's. But then, as you know, they start to vanish rather abruptly as we go into the 21st century.

From the very longrun point of view, then, these trust funds are not in great shape. But perhaps more important, I think Social Security and Medicare need to be compared with all of the other expenditures of Government. We do know that they are not fully funded systems. I might feel differently about them if they were indeed like private pensions and there was a funded amount of money there. But they are not. They are transfer systems.

But if you think they are developing too large a surplus, one could consider reductions in payroll taxes offset by some increase in income taxes, although I know how hard this is to do legislatively.

Mr. FROST. And that is really beyond the scope of this particular hearing.

Mr. PENNER. Yes, way beyond it.

Mr. FROST. I was really directing my attention to the surplus in the hospital trust fund as it shows in your testimony, and that is a question that we will be facing in this committee if we are, in fact, next year asked to not grant a full inflation adjustment for DRG's. And that may well be the position of the administration. We don't know at this point what their position will be. That may well be.

I have one other question then I would like to call on Mr. MacKay.

I found very interesting your suggestion of a tradeoff between the disproportionate share subsidy and the indirect teaching subsidy. I noticed that in your testimony in reviewing it over the weekend. Of course, you stated that again today, that if to the extent we provided a disproportionate share subsidy, that we could reduce the indirect teaching subsidy as one way of funding that.

Is, in fact—is that a strong recommendation from you, Dr. Penner, that that be the source of subsidy for the disproportionate share?

Mr. PENNER. No; as you know, Mr. Chairman, we never make recommendations like that. This is just one more choice we present you with in terms of deciding this issue.

Mr. FROST. Mr. MacKay.

Mr. MACKAY. I'm very interested in your testimony, Dr. Penner, because I think this is one of the key programs we have gotten into which maybe has potential to work with the Government funding system, back more towards a free market mechanism.

I wonder two things: Does CBO do any overview of the determination of the actual costs in the prospective payments system?

In other words, we are presumably trying to reimburse on the basis of average costs of an efficiently operated hospital. And we sort of started in midstream with some assumptions of what those costs were.

Mr. **Penner**. We have not been reviewing it in a formal way in the sense of being a Monday morning quarterback about it. We are trying to keep track of the effects in great detail to find out what is happening to one type of hospital versus another.

The data, however, are slow in coming in. As Mr. Waxman said, there is a lot we do not know about how the system is operating right now. But we are trying to track it as well as we can with what data we have.

Mr. **MacKay**. What is bothering me, I guess, is it seems we start in asking the cooperation of the hospital administrators and trustees in trying to move toward a different reimbursement system, and then at the same time we start freezing the reimbursement almost like saying regardless of what the data show, we don't have the money.

We are going to be sending them signals that say to them, you are better off if you start playing the games again. And I would assume you can play games under a DRG system as easily as you could under the old system. What I am worrying about is, who is doing studies to determine what the actual costs should be in an efficiently run hospital.

Mr. **Penner**. Of course we do have the ProPAC Commission that is following the situation very carefully and making recommendations. And as I say, we are trying to track it as best we can.

I would just modify one thing you said. I think the whole point of the DRG system is to reduce greatly what you have called game playing. Now, that does not mean it eliminates it, certainly you are right about that. And there is concern about something we call "DRG creep," where patients are classified into more and more expensive categories and so forth. But again, we simply do not have the evidence at this moment to reach any firm conclusion on that.

Mr. **MacKay**. In my observation of what is actually happening in my local area, people seem to be rushing to take sophisticated equipment out of hospitals and set it up so that CAT scans and other very sophisticated devices can be reimbursed under the old system instead of under the PPS.

It would appear to me that if that continues, clearly you are starting a new kind of game. In fact, I am told that there are arrangements now being made so that the equipment is owned by limited partnerships of doctors, clearly to give them an incentive to order more tests to get the equipment paid for, since they get part of the tax writeoff and also part of the profits from them. In fact, these are being set up all over the country. Is there anybody following any of this?

Mr. **Penner**. I think people are trying to track it. I think what you have here is a situation in which the Government is trying to impose what in essence are price controls. And we know from history how badly that generally works when you try to apply it to the private sector.

So, just as you say, any time you control one part of the system, people will try to figure out ways to get into a less controlled part of the system. I think that is inevitable.

On the other hand, I do think though, that it would be the general presumption of most experts, that despite such game playing, this is a much superior system for paying for hospital services.

Mr. **MacKay**. I agree with that general conclusion, and I am a strong supporter. I wonder though, once you have reached that conclusion, how you justify not going on and extending this to physician services, and also extending it where feasible, to out patient?

Mr. **Penner**. I think that we certainly will have to look at that even more narrowly. Certainly we will have to look at extending it to capital expenditures.

The physician situation is very much more complicated, I think, than the hospital situation, especially when you have a system in which physicians have a choice about whether or not to take assignment. I think that if you look at some sort of system of fee setting for physicians, you also have to look at that choice very carefully. Obviously, the fee system could obviously be easily avoided by doctors not taking assignment. Then, it gets much more complicated very fast when you start talking about applying this system to physicians.

We think in terms of many options that one looks at, there should probably be some sort of demonstration process first, so that we can get some of the major wrinkles out of the process before one goes nationwide with it.

Mr. **MacKay**. Thank you, Mr. Chairman.

Mr. **Frost**. Dr. Penner, again we appreciate your testimony very much. You made a very comprehensive statement. We appreciate your being with us and we look forward to seeing you—I believe you are scheduled to come back to the Budget Committee later on. I don't know if it is this week, but it is soon.

Mr. **Penner**. It will be on October 10.

Mr. **Frost**. You will be testifying before us again. We always enjoy hearing from you. Thank you very much.

Mr. **Penner**. Thank you.

Mr. **Frost**. Our next witness is C. McClain Haddow, Acting Administrator, Health Care Financing Administration, Department of Health and Human Services.

STATEMENT OF C. McCLAIN HADDOW, ACTING ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY HENRY R. DESMARAIS, M.D., ACTING DEPUTY ADMINISTRATOR

Mr. **Haddow**. Mr. Frost, it is a pleasure to be here today to discuss the prospective payment system, our original objectives, accomplishments to date, and our thoughts on future initiatives to refine the system.

Accompanying me today is Henry Desmarais, who is the Acting Deputy Administrator of the Health Care Financing Administration.

I have submitted my complete statement for the record and would like to summarize by making a few important points.

First, I want to emphasize that the progress that has been made during this administration to bring down hospital cost increases has been successful. In 1980 the economic inflation, as measured by the Consumer Price Index, was greater than 13 percent. And the growth rate of Medicare payment outlays was almost 22 percent.

By the close of 1984, the CPI had declined to 4 percent and the Medicare growth rate was down to 6.3 percent.

In conjunction with this achievement, our competitive reforms, including the implementation of a prospective payment system for hospitals, have contributed to the solvency of the hospital insurance trust fund, which our actuaries now project as financially sound through 1998.

However, the disparity between the growth of Medicare, and the growth of the overall economy clearly demonstrates our need to carry on our Medicare cost-saving efforts. We estimate that over the next 25 years, we will accrue a $1 trillion deficit, unless we continue our efforts toward cost-containment activity.

Hospital economic incentives have been restructured through the conversion of our reimbursement system from a retrospective cost-based one to a prospective payment system based on patient diagnoses. As we approach the third year of our transition to a fully national prospective rate system, the results have been highly positive. Several trends in hospital behavior patterns illustrate the efficient and cost-effective utilization of resources which hospitals have adopted.

The average length of stay has declined; it is now 7.7 days for all PPS hospitals, down from 10 days prior to PPS. There is a downward trend in Medicare admissions as has been seen nationally over the last several years. In the first year of PPS, admissions declined almost 2 percent.

Additionally, the hospital industry reports that there have been favorable financial outcomes resulting from positive and efficient reactions to the new payment system.

American Hospital Association data indicates that 5,800 hospitals last year doubled their surplus revenue. And the Federation of American Hospitals indicates the 1,200 for-profits, increased income 44 percent last year, on only a 13-percent increase in revenues.

We are particularly pleased that there is no evidence that the quality of care has been adversely impacted by PPS, and we are committed to our objective of maintaining quality and access to care for our beneficiaries.

We have committed substantial resources to monitor the quality of care. Vigorous monitoring by PRO's has enabled Medicare to maintain a high level of quality care.

We believe that the Peer Review Organization Program has actually enhanced review under Medicare by directing review activities specifically toward those quality, cost, and utilization areas most likely to be affected by PPS.

The new approach to quality review under the PRO Program has placed greater responsibility on individual PRO's by requiring them to develop measurable performance objectives more specific to utilization patterns in their communities.

PRO's must also perform specific tasks designed to assure quality under PPS. For example, they must validate that cases are assigned to correct diagnosis related groups—DRG's; they must review 100 percent of transfers that occur; they must review all readmissions occurring within 7 days of discharge, and make claims denials when the readmission is due to premature discharge or unnecessary transfers; they must review outliers on a sample basis; and they must confirm any hospital notice of noncoverage.

We would like to emphasize that PRO's also have the authority to sanction any provider responsible for inappropriate care, including exclusion from the program.

Our fiscal year 1986 initiatives for the Medicare Program are a vital part of our efforts to refine the PPS and will help us to maintain our progress in containing health care costs. PPS rates will be maintained at 1985 levels, we hope.

After adjusting for changes in the market basket, case mix, productivity and pricing patterns, our analysis showed that not only were we justified in freezing the rates for 1986, but we could have reduced them, had we chosen to do so, by as much as 4.42 percent.

The new regulation contains refinements in the system that include a new wage index which accounts for differences in part-time hospital employment practices, thus making the system more fair.

All DRG wages have been updated to reflect technological changes.

To assure financial stability, we must continue our efforts to refine the program. Through positive competitive incentives, we believe we can continue to provide basic health care needs for our Medicare beneficiaries and still contain the growth in medical costs.

Our published regulations prescribe that direct medical education payments be maintained at current levels for 1 year. We believe this will provide an incentive for hospitals to contain the cost of medical education programs and curtail the training of surplus physicians.

Furthermore, we believe the doubling of the indirect teaching adjustment should be discontinued, as there is no empirical basis for an 11.59-percent add-on to the PPS rates for teaching hospitals.

Another cost-saving initiative is our proposal to extend the existing freeze on physician fees for an additional year. It is notable that the rate of growth and expenditures for physician services remains high. It has begun to decline to levels more in line with the rate of growth in the general economy. We believe this is in part attributable to the physician fee freeze of last year.

The percentage distribution of fiscal year 1984 Medicare expenditures illustrates the magnitude of the areas in which our cost-saving restructuring initiatives are directed. Non-PPS hospitals received the largest portion of our Medicare dollars, followed by PPS hospitals and physicians.

Although we are continuing to refine the hospital PPS system, we are also keenly aware of the need for cost-control initiatives in other areas of the delivery system. Our future activities address issues necessary to refine PPS so that it is up to date and capable of responding to the evolving health care marketplace.

Our research and demonstration efforts are being conducted to test new delivery systems to enhance our competitive payment reforms, while assuring that high-quality care is maintained.

We believe that capitation has terrific potential to achieve these objectives. Capitated health care programs have the distinct advantage of including more local decisionmaking in structuring plans, providing for additional benefits, and delivering care more efficiently and cost effectively.

Certainly, we are seeing strong positive response to health maintenance organizations—HMO's and competitive medical plans—CMP's.

Beneficiaries will be free to choose the plan that best suits their needs, and retain the right to disenroll at any time and rejoin the traditional fee-for-service Medicare system if they choose to do so.

We will soon submit to Congress our voluntary voucher proposal. This proposal will expand the pool of plans qualifying for capitation payments by allowing Medicare beneficiaries the option of choosing a voucher to enroll in a wider array of private health plans, in addition to HMO's and CMP's.

We are studying capitation programs called social HMO's, which provide consolidated health and social services, including case management in a delivery system organized to provide comprehensive health and community-based long-term care benefits.

We are continuing our ongoing activities to refine PPS, and these include: The modified wage index, which is used to adjust the labor portion of the DRG rates; our studies to adjust the rates to account for severity of illness; how to deal equitably with rural hospitals which compete with closely neighboring hospitals in urban areas; the appropriate level of payment to hospitals which serve a disproportionate share of low income patients; and the integration of capital payments, exempt facilities and medical education costs into the overall system.

Other areas which we are presently studying include: Our comprehensive effort to reform payments to physicians; improved methods to pay for laboratory services and durable medical equipment such as a competitive bidding system; alternate payment methodologies for post-hospital services provided by skilled nursing facilities; and home health agencies.

And finally, the national channeling demonstration which fulfills the long-term care needs of the elderly through a community based system of care assessment, planning and management.

To assure the financial stability of the Medicare system we must continue our efforts to refine the program. Through positive competitive incentives, we believe we can continue to provide basic health care needs for our Medicare beneficiaries and still contain the growth in medical costs.

Thank you, Mr. Frost, for this opportunity to be here this afternoon, and I welcome any questions.

[Testimony resumes on p. 65.]

[The prepared statement of Mr. Haddow follows:]

PREPARED STATEMENT OF C. MCCLAIN HADDOW

IT IS A PLEASURE TO BE HERE TODAY TO DISCUSS THE PROSPECTIVE PAYMENT SYSTEM (PPS); OUR ORIGINAL OBJECTIVES, ACCOMPLISHMENTS TO DATE, AND OUR THOUGHTS ON FUTURE INITIATIVES TO REFINE THE SYSTEM.

WITHIN THE PAST 3 YEARS THIS ADMINISTRATION HAS PUT IN PLACE THE MOST SIGNIFICANT CHANGES IN THE PROGRAM SINCE MEDICARE WAS ENACTED. THESE CHANGES HAVE STRENGTHENED THE FINANCIAL STATUS OF THE PROGRAM AND INCREASED SAFEGUARDS OVER THE QUALITY OF CARE.

CONGRESS AND THIS ADMINISTRATION HAVE WORKED IN CLOSE COLLABORATION TO HALT SPIRALING HEALTH CARE COSTS. IN OUR JOINT EFFORT, COMPETITIVE REFORMS HAVE BEEN PUT IN PLACE TO CHANGE THE PERVERSE FINANCIAL INCENTIVES WHICH HAD CONTRIBUTED TO HEALTH CARE INFLATION.

ORIGINAL OBJECTIVES

ONE OF OUR MOST FUNDAMENTAL OBJECTIVES HAS BEEN TO RESTRAIN THE RATE OF HOSPITAL COST INCREASE, AND INSURE THAT INFLATION IN THE HEALTH MARKET PLACE IS CONTAINED TO THE POINT WHERE IT NO LONGER THREATENS THE FINANCIAL STABILITY OF MEDICARE AND OTHER FEDERALLY-SUPPORTED

HEALTH CARE PROGRAMS. WHEN THIS ADMINISTRATION TOOK OFFICE, INFLATION AS MEASURED BY THE CONSUMER PRICE INDEX WAS GREATER THAN 13 PERCENT. MEDICARE COSTS WERE RISING AT A RATE OF 19 PERCENT ANNUALLY. BY LAST YEAR THE GROWTH OF THE CPI DECLINED DRAMATICALLY, TO 4 PERCENT AND THE MEDICARE GROWTH RATE IS NOW DOWN TO 6.3 PERCENT. THIS HAS BEEN ACCOMPLISHED THROUGH REFORMS WHICH HAVE RESULTED IN AN OVERALL DECREASE IN ECONOMIC INFLATION AND UNEMPLOYMENT, AND THROUGH SPECIFIC HEALTH CARE REFORMS DESIGNED TO CONTROL COSTS WHILE MAINTAINING ACCESS TO QUALITY HEALTH CARE FOR OUR BENEFICIARIES.

ONE OF THE MOST CELEBRATED ACHIEVEMENTS FROM OUR COMPETITIVE REFORMS CONCERNS THE SOLVENCY OF THE HOSPITAL INSURANCE TRUST FUND. IN THE 1982 TRUSTEE'S REPORT OUR ACTUARIES PROJECTED THAT THE FUND WOULD BE DEPLETED DURING 1987. IN THE MOST RECENT REPORT, THE ESTIMATE WAS CHANGED TO 1998. THIS TURN AROUND WAS LARGELY DUE TO ECONOMIC IMPROVEMENTS AND TO THE REDUCTION IN THE RATE OF GROWTH IN MEDICARE PROGRAM OUTLAYS UNDER PPS.

A PRIMARY OBJECTIVE OF THE MEDICARE PPS REFORM IN 1983 WAS TO RESTRUCTURE HOSPITAL ECONOMIC INCENTIVES.

FOR OVER 17 YEARS, HOSPITALS WERE REIMBURSED ON A REASONABLE COST BASIS WHICH FAILED TO ENCOURAGE EFFICIENCY SINCE WE REIMBURSED BASICALLY WHATEVER COSTS WERE INCURRED. UNDER PPS, HOSPITALS ARE PROVIDED A KNOWN PAYMENT SET IN ADVANCE THAT IS BASED ON THE PATIENT'S DIAGNOSIS. THERE ARE A NUMBER OF EFFECTS WHICH RESULT FROM BASING PAYMENT ON TYPE OF DISCHARGE. HOSPITALS ARE REWARDED FOR CAREFUL UTILIZATION OF RESOURCES, AS THE SYSTEM ENCOURAGES MANAGEMENT TO ORGANIZE AND PROVIDE SERVICES IN AN EFFICIENT AND COST-EFFECTIVE MANNER. IN ADDITION, A PAYMENT BASIS WHICH IDENTIFIES THE PRODUCT BEING PURCHASED REINFORCES THE ROLE OF THE FEDERAL GOVERNMENT AS A PRUDENT BUYER OF SERVICES AND ENSURES GREATER PREDICTABILITY OF GOVERNMENT OUTLAYS.

THE MOST CRUCIAL OBJECTIVE THROUGHOUT THESE PAYMENT REFORMS HAS BEEN TO MAINTAIN QUALITY ASSURANCE AND ACCESS TO CARE FOR OUR BENEFICIARIES. OUR MONITORING OF HOSPITAL BEHAVIOR THROUGH PEER REVIEW ORGANIZATIONS INDICATES THAT BENEFICIARIES ARE CONTINUING TO RECEIVE HIGH QUALITY CARE. I WILL ADDRESS QUALITY IN MORE DETAIL LATER.

IMPLEMENTATION AND ACCOMPLISHMENTS

THE PAYMENT SYSTEM IS NOW NEARING THE END OF THE SECOND YEAR OF A THREE-YEAR PHASE-IN FROM A COMBINATION

OF HOSPITAL-SPECIFIC AND REGIONAL RATES TO A FULLY NATIONAL PROSPECTIVE RATE. CONGRESS PROVIDED THE THREE-YEAR TRANSITION PERIOD IN ORDER TO ALLOW HIGH COST HOSPITALS TIME TO CHANGE THEIR BEHAVIOR IN ORDER TO LIVE WITHIN THE NATIONAL RATES. IN FISCAL YEAR 1987, A FULLY NATIONAL RATE WILL BE BASED SOLELY ON THE NATIONAL URBAN AND RURAL AVERAGES, ADJUSTED FOR DIFFERENCES IN AREA WAGE LEVELS.

IMPLEMENTATION OF THE PPS TO DATE HAS BEEN HIGHLY SUCCESSFUL. THIS IS A TRIBUTE TO THE COOPERATION OF HOSPITALS, FISCAL INTERMEDIARIES AND OTHER ORGANIZATIONS WHICH HAVE WORKED SO CLOSELY WITH US IN THIS EFFORT. A TOTAL OF 5,405 OR 81 PERCENT OF ALL MEDICARE CERTIFIED HOSPITALS ARE NOW ON PPS AND ABOUT 83 PERCENT OF ALL PAYMENTS FOR INPATIENT HOSPITAL SERVICES IN FISCAL YEAR 1985 HAVE BEEN MADE UNDER PPS. CHANGES IN HOSPITAL BEHAVIOR TO ADJUST TO THE NEW SYSTEM HAVE BEEN POSITIVE. REDUCTIONS IN LENGTH OF STAY HAVE MODERATED THE AMOUNT OF RESOURCES NEEDED TO PROVIDE ROUTINE CARE. AVERAGE LENGTH OF STAY PER DISCHARGE FOR PPS HOSPITALS HAS DECLINED FROM 9.3 DAYS IN FY 1983 TO 7.7 DAYS IN THE FIRST 8 MONTHS OF FY 1985.

WHEN THE PPS LEGISLATION WAS BEING DEBATED BY THE CONGRESS MANY BELIEVED THAT THE SYSTEM WOULD ENCOURAGE HOSPITALS TO ADMIT AN EXCESSIVE NUMBER OF PATIENTS, THEREBY EXPOSING MEDICARE BENEFICIARIES TO UNWARRANTED RISKS. FORTUNATELY, THESE CONCERNS HAVE NOT BEEN REALIZED. MEDICARE ADMISSIONS UNDER PPS HAVE FOLLOWED THE DOWNWARD TREND IN ADMISSIONS FOR THE NON-MEDICARE POPULATION SEEN NATIONALLY OVER THE LAST SEVERAL YEARS. IN THE FIRST YEAR OF PPS ADMISSIONS DECLINED ALMOST 2 PERCENT. AS A RESULT OF THIS TREND, AS WELL AS DECLINING LENGTH OF STAY, PART A OUTLAYS FOR INPATIENT HOSPITAL SERVICES GREW BY ONLY 7 PERCENT IN 1984. THAT'S THE SMALLEST INCREASE IN OUTLAYS SINCE FISCAL YEAR 1970.

THE PROSPECTIVE PAYMENT SYSTEM ALSO PRODUCED DIVIDENDS ON THE PART B SIDE. THE REDUCTION IN ADMISSIONS AND LENGTH OF STAY RESULTED IN LOWER OUTLAYS FOR INPATIENT HOSPITAL PHYSICIAN SERVICES. THIS, COMBINED WITH THE PHYSICIAN FEE FREEZE MANDATED BY THE DEFICIT REDUCTION ACT OF 1984, REDUCED THE INCREASE IN PART B OUTLAYS TO HALF WHAT IT HAD BEEN OVER THE PREVIOUS TEN YEARS.

THERE IS ALSO EVIDENCE OF A DECREASE IN ANCILLARY SERVICES WITHIN HOSPITALS AND DEVELOPMENT OF MORE COST EFFECTIVE METHODS FOR PROVIDING SERVICES INVOLVING HIGH

TECHNOLOGY PROCEDURES. WE ARE MOVING AWAY FROM THE OVERUTILIZATION OF SERVICES AND THE DUPLICATION OF EQUIPMENT THAT PREDOMINATED THE PAST. WE BELIEVE THE INCREASED SHARING OF SERVICES BETWEEN PROVIDERS, THE INCREASED SPECIALIZATION OF CASES WITHIN HOSPITALS WHICH ARE BEST EQUIPPED TO HANDLE THEM, AND GREATER COMPETITION AMONG HOSPITALS MAY ALL LEAD TO HIGHER QUALITY SERVICE.

REPORTS FROM THE HOSPITAL INDUSTRY INDICATE THAT HOSPITALS ARE DOING WELL FINANCIALLY AND HAVE REACTED POSITIVELY AND EFFICIENTLY TO THE NEW PAYMENT SYSTEM. THE AMERICAN HOSPITAL ASSOCIATION (AHA) REPORTS THAT SURPLUS REVENUE (INCOME FROM TREATING PATIENTS LESS EXPENSES) FOR ALL 5800 U.S. HOSPITALS MORE THAN DOUBLED IN 1984. ACCORDING TO THE FEDERATION OF AMERICAN HOSPITALS, THE NET INCOME FOR THE 1200 U.S. FOR PROFIT HOSPITALS JUMPED 44 PERCENT ON ONLY A 13 PERCENT INCREASE IN REVENUES.

ACCORDING TO THE HOSPITAL INDUSTRY, ADMISSIONS DROPPED 4 PERCENT IN 1984. IN SPITE OF THIS, TOTAL HOSPITAL REVENUE MARGIN ROSE FROM 5.1 PERCENT TO 6.5 PERCENT.

WE ARE EXTREMELY ENCOURAGED BY THE INDUSTRY RESULTS AND BELIEVE THEY FURTHER SUPPORT OUR FY 1986 PROPOSALS.

FISCAL YEAR 1986 INITIATIVES

I WILL NOW DESCRIBE OUR MEDICARE INITIATIVES FOR FISCAL YEAR 1986 WHICH ARE DIRECTLY RELATED TO PPS. AS PUBLISHED IN REGULATIONS ON SEPTEMBER 3, WE ARE MAINTAINING THE HOSPITAL PROSPECTIVE PAYMENT RATES FOR ONE YEAR AT THE CURRENT LEVEL. THIS IS STRONGLY SUPPORTED BY SOUND PROGRAMMATIC REASONS FOR NOT INCREASING THE RATES IN 1986. WE HAVE ANALYZED RECENT ECONOMIC DEVELOPMENTS IN THE HOSPITAL INDUSTRY WHICH WOULD AFFECT ITS FINANCIAL VIABILITY UNDER PPS. SPECIFICALLY, WE ADJUSTED THE PROJECTED HOSPITAL MARKETBASKET FOR 1986 TO ACCOUNT FOR DECREASED COSTS RESULTING FROM PRODUCTIVITY INCREASES AND THE ELIMINATION OF INEFFECTIVE PRACTICE PATTERNS. WE ALSO APPLIED A CORRECTIVE FACTOR TO ACCOUNT FOR UNFORECAST INCREASES IN CASE MIX, AND CORRECTED AN ERROR IN FORECASTING THE 1985 MARKETBASKET. THESE CALCULATIONS INDICATED THAT A 4.42 PERCENT DECREASE IN THE 1986 RATES WAS JUSTIFIED. IN ADDITION, THE GENERAL ACCOUNTING OFFICE ALSO BELIEVES THAT THE RATES MAY HAVE BEEN SET TOO HIGH BECAUSE THEY WERE BASED ON UNAUDITED COST REPORTS WHICH WERE THE BEST DATA AVAILABLE AT THE TIME. GAO REPORTED THAT USE OF UNAUDITED COST DATA MAY HAVE RESULTED IN RATES THAT WERE AS MUCH AS 4.3 PERCENT

TOO HIGH. I WOULD NOTE THAT WHILE JUSTIFICATION EXISTS FOR LOWERING THE PAYMENT RATES, WE ELECTED NOT TO DO SO.

FURTHER, INCREASING FY 1986 RATES WHEN FY 1985 RATES HAVE BEEN DEMONSTRATED TO BE OVERSTATED CLEARLY WOULD NOT COMPORT WITH THE STATUTORY REQUIREMENT THAT THE RATES REPRESENT PAYMENT FOR EFFICIENTLY DELIVERED CARE. THE ADMINISTRATION BELIEVES ANY INCREASE IN THE PAYMENT RATES, AS APPROVED BY THE HOUSE AND SENATE COMMITTEES, IS NOT WARRANTED, AND IS UNNECESSARY FOR EFFICIENTLY MANAGED HOSPITALS.

THE REGULATIONS ALSO CONTAIN A NUMBER OF REFINEMENTS TO THE PPS INCLUDING A NEW WAGE INDEX BASED ON OUR SURVEY DATA, WHICH TAKES INTO ACCOUNT AREA-BY-AREA DIFFERENCES IN PART-TIME HOSPITAL EMPLOYMENT PRACTICES. WE BELIEVE THAT APPLYING THE SURVEY-BASED WAGE INDEX RETROACTIVELY, AS REQUIRED BY EXISTING LAW, WOULD BE INCONSISTENT WITH THE PPS PREMISE THAT HOSPITALS KNOW IN ADVANCE OF EACH DISCHARGE THE AMOUNT THEY CAN BE EXPECTED TO BE PAID BY MEDICARE. WE SUPPORT THE HOUSE AND SENATE COMMITTEE PROPOSALS TO USE THE NEW WAGE INDEX PROSPECTIVELY.

HOWEVER, WE STRONGLY OPPOSE THE WAYS AND MEANS COMMITTEE PROVISION FOR A ONE YEAR DELAY IN THE TRANSITION TO A FULLY NATIONAL PROSPECTIVE PAYMENT SYSTEM. THE POSITIVE RESULTS OF THE SYSTEM CONVINCE US THAT THE TRANSITION SHOULD CONTINUE ON SCHEDULE. ANY DELAY WOULD PERMIT HOSPITALS WITH HISTORICALLY HIGHER COSTS TO CONTINUE RECEIVING HIGHER PAYMENTS AT THE EXPENSE OF THOSE HOSPITALS WHICH HAVE BEEN PROVIDING CARE IN A MORE EFFICIENT, LESS COSTLY MANNER. A DELAY IN THAT SCHEDULE COULD BE INTERPRETED AS AN INDICATION OF A LACK OF CONFIDENCE IN THE SYSTEM, THEREBY UNDERMINING THE SPIRIT OF COOPERATION AND STATE AND PRIVATE SECTOR EFFORTS WHICH HAVE FACILITATED ITS IMPLEMENTATION.

WE ALSO PROMULGATE REGULATIONS ON JULY 5 WHICH MAINTAIN DIRECT MEDICAL EDUCATION PAYMENTS BE MAINTAINED AT CURRENT LEVELS FOR ANOTHER YEAR. AS YOU ARE AWARE, THESE PAYMENTS ARE MADE ON A COST BASIS AND ARE IN ADDITION TO THE AMOUNT HOSPITALS RECEIVE UNDER THE PROSPECTIVE PAYMENT SYSTEM. IT IS OUR VIEW THAT AFTER 20 YEARS OF PROGRAM EXPERIENCE, STATES AND LOCALITIES, MEDICAL SCHOOLS, AND PRIVATE PHILANTHROPIC GROUPS SHOULD ASSUME MORE RESPONSIBILITY FOR THE COSTS OF MEDICAL EDUCATION. OUR VIEW IS CONSISTENT WITH THE

ORIGINAL INTENT OF CONGRESS IN 1966 WHEN THE DIRECT MEDICAL EDUCATION PAYMENT WAS SEEN AS A TEMPORARY SUBSIDY. IN ADDITION, WE BELIEVE THAT MAINTAINING CURRENT PAYMENT LEVELS WILL PROVIDE AN INCENTIVE FOR HOSPITALS TO CONTAIN THE COST OF MEDICAL EDUCATION PROGRAMS AND CURTAIL THE TRAINING OF SURPLUS PHYSICIANS. THE PUBLIC HEALTH SERVICE NOW ESTIMATES THAT BY 1990 THERE WILL BE AN OVERSUPPLY OF 35,000 PHYSICIANS.

LIMITING WHAT WE WILL PAY FOR MEDICAL EDUCATION SHOULD PROVIDE AN INCENTIVE FOR THE MEDICAL EDUCATION COMMUNITY TO EXAMINE ITS PRIORITIES AND BEGIN TO SHAPE ITS RESIDENCY PROGRAMS TO CONFORM TO TODAY'S -- AND TOMORROW'S -- HEALTH CARE MARKET PLACE.

MEDICARE ALSO REIMBURSES HOSPITALS AN ADDITIONAL AMOUNT WHICH RECOGNIZES INDIRECT TEACHING COSTS; THAT IS, THE ADDITIONAL PATIENT CARE COSTS ASSOCIATED WITH HOSPITALS THAT TRAIN PHYSICIANS. IN DEVELOPING THE PROSPECTIVE PAYMENT LEGISLATION, CONGRESS ELECTED TO DOUBLE THE FACTOR USED IN CALCULATING THIS ADJUSTMENT. THIS ADD-ON TO THE PPS RATES, WHICH IS NOW 11.59 PERCENT, HAS PRODUCED AN UNINTENDED WINDFALL. WE HAVE ESTIMATED THAT IF ALL HOSPITALS UNDER PPS HAD BEEN REIMBURSED SOLELY ON THE BASIS OF THE FEDERAL REGIONAL RATE IN

FISCAL YEAR 1984, THE APPROXIMATELY 118 "HEAVY" TEACHING HOSPITALS (THOSE HAVING A RATIO OF ONE OR MORE INTERN OR RESIDENT FOR EVERY FOUR BEDS) WOULD HAVE RECEIVED AN AVERAGE $556 PER CASE FOR DIRECT MEDICAL EDUCATION IN ADDITION TO THEIR DRG PAYMENT OF $4,079 PER CASE. FOR INDIRECT MEDICAL EDUCATION, THEY WOULD HAVE RECEIVED A 53 PERCENT ADD-ON OF $2,158 PER CASE. IT SHOULD BE NOTED THAT THE FULL ADD-ON WILL NOT BE PAID TO HOSPITALS UNTIL FY 87 WHEN THE PPS IS FULLY PHASED-IN. SINCE THERE IS NO EMPIRICAL BASIS FOR DOUBLING THE FORMULA, WE BELIEVE THAT SUBSTANTIAL PAYMENTS TO TEACHING HOSPITALS RESULTING FROM THAT ACTION SHOULD BE DISCONTINUED. THE REDUCTION IN THE INDIRECT TEACHING ADJUSTMENT APPROVED BY THE HOUSE AND SENATE COMMITTEES DOES NOT GO FAR ENOUGH IN CURBING THESE EXCESSIVE PAYMENTS.

ANOTHER COST SAVING INITIATIVE IS OUR LEGISLATIVE PROPOSAL TO EXTEND THE EXISTING FREEZE ON PHYSICIANS' FEES FOR AN ADDITIONAL YEAR. BOTH HOUSE AND SENATE BILLS INCLUDE PROVISIONS WHICH WOULD CONTINUE THE FREEZE ON NON-PARTICIPATING PHYSICIANS' FEES. I SHOULD LIKE TO NOTE HERE THAT THE PHYSICIAN FEE FREEZE ENACTED LAST YEAR HAS PROVIDED ADDITIONAL PROTECTION TO MEDICARE BENEFICIARIES AND REDUCED THE RATE OF GROWTH FOR MEDICARE EXPENDITURES FOR PHYSICIANS' SERVICES.

BENEFICIARIES HAVE BEEN FAVORABLY AFFECTED BY THE FREEZE IN SEVERAL WAYS: REDUCED COINSURANCE, LOWER PREMIUMS, AND REDUCED EXTRA BILLING THAT WOULD HAVE OCCURRED IF FEES WERE PERMITTED TO INCREASE. IN ADDITION, ALMOST 70 PERCENT OF MEDICARE CLAIMS FOR PHYSICIANS' SERVICES ARE NOW PAID UNDER ASSIGNMENT.

IT IS CLEAR THAT A FREEZE DOES NOT ADDRESS THE OVERALL ISSUE OF APPROPRIATE PHYSICIAN REIMBURSEMENT. CONGRESS HAS ASKED US TO STUDY PHYSICIAN REIMBURSEMENT REFORM. THIS PROJECT IS A HIGH PRIORITY IN HCFA AND WE ARE CURRENTLY EXPLORING A NUMBER OF OPTIONS.

THE SOCIAL SECURITY AMENDMENTS OF 1983 REQUIRED US TO REPORT ON THE ADVISABILITY OF PAYING HOSPITAL INPATIENT PHYSICIAN SERVICES ON THE BASIS OF HOSPITAL DIAGNOSTIC RELATED GROUPS (DRG). THE REPORT INVOLVES MERGING THE HOSPITAL AND PHYSICIAN CLAIMS DATA BASES; STUDYING THE VARIATION IN PHYSICIAN CHARGES WITHIN EACH DRG; ASSESSING THE FEASIBILITY OF IMPLEMENTATION OPTIONS; AND ANALYZING THE EXPECTED IMPACT ON BENEFICIARIES, PHYSICIANS, HOSPITALS, AND THE BUDGET. THE PHYSICIAN DRG REPORT WILL ALSO INCLUDE INFORMATION ON CHANGES IN THE VOLUME AND MIX OF PHYSICIAN SERVICES THAT MAY HAVE RESULTED FROM THE FEE FREEZE.

WE ARE ALSO CAREFULLY EXAMINING OTHER PHYSICIAN REIMBURSEMENT OPTIONS SUCH AS A FEE SCHEDULE. THE FEE SCHEDULE IS A SERVICE PRICING MECHANISM WHILE THE RELATIVE VALUE SCALE USES FACTORS OTHER THAN PRICE, SUCH AS COGNITIVE SKILLS, AS A BASIS FOR PAYMENT. ANOTHER OPTION ADDRESSED IN THE REPORT IS GEOGRAPHIC CAPITATION, OR THE PROVISION OF A SINGLE PAYMENT, DETERMINED IN ADVANCE, FOR ALL CARE A BENEFICIARY IN A GIVEN GEOGRAPHIC REGION MAY REQUIRE DURING A YEAR. THE CONCEPT OF CAPITATION EMBRACES A LARGER PAYMENT FOR A BROADER RANGE OF SERVICES, TO ENHANCE COST CONTROL AND EFFICIENCY. ANOTHER INITIATIVE WITH GREAT POTENTIAL FOR PROVIDING COST-EFFECTIVE HEALTH CARE COVERAGE IS OUR VOUCHER PROPOSAL WHICH I WILL DISCUSS LATER.

QUALITY OF CARE

AS I NOTED EARLIER, THERE IS NO DATA WHICH INDICATES THAT THE PPS SYSTEM HAS ADVERSELY IMPACTED ON THE HIGH QUALITY OF CARE THAT HAS BEEN A TRADITION IN OUR NATION'S HEALTH COMMUNITY. WORKING IN PARTNERSHIP WITH PPS IS THE PEER REVIEW ORGANIZATION (PRO) PROGRAM. IN CHANGING THE INCENTIVES UNDER WHICH HOSPITALS PROVIDE

SERVICES, BOTH CONGRESS AND THE ADMINISTRATION WERE AWARE THAT MEDICAL REVIEW HAD TO CHANGE. THE PRO AMENDMENTS IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 SET A FIRM FOUNDATION FOR THIS REDIRECTION. WE BELIEVE THE PRO PROGRAM HAS ENHANCED PEER REVIEW UNDER MEDICARE BY DIRECTING REVIEW ACTIVITIES SPECIFICALLY TOWARD THOSE QUALITY, COST, AND UTILIZATION AREAS MOST LIKELY TO BE AFFECTED BY PPS.

A MAJOR FEATURE OF THE PRO PROGRAM IS THE USE OF MEASURABLE, QUANTIFIABLE PERFORMANCE OBJECTIVES FOR ADMISSIONS, UTILIZATION, AND QUALITY REVIEW. THROUGH THE USE OF THESE OBJECTIVES IN OUR CONTRACTS, PROS ARE REQUIRED TO ACCOMPLISH GOALS THEY THEMSELVES SET. THIS NEW APPROACH IS A VAST IMPROVEMENT OVER WHAT PREVAILED BEFORE AND ENSURES THAT PROS WILL ACTIVELY MONITOR THE QUALITY OF CARE IN THEIR STATES.

CONCERN HAS BEEN EXPRESSED THAT UNDER PPS, HOSPITALS MAY BE PREMATURELY DISCHARGING MEDICARE PATIENTS. AS A SAFEGUARD AGAINST SUCH PRACTICES WE REQUIRE PROS TO REVIEW ALL TRANSFER CASES AND ALL HOSPITAL READMISSIONS THAT OCCUR WITHIN SEVEN DAYS OF A HOSPITAL DISCHARGE. WHERE THE PRO FINDS THAT THE READMISSION RESULTED

BECAUSE OF A PREMATURE DISCHARGE OR THAT A TRANSFER WAS INAPPROPRIATE, IT IS REQUIRED TO DENY PAYMENT FOR THE READMISSION. IN THESE INSTANCES, THE HOSPITAL MAY NOT, IN TURN, CHARGE THE BENEFICIARY FOR THE READMISSION OR THE TRANSFER. WHERE THE PRO IDENTIFIES OTHER INSTANCES OF POOR QUALITY IT MUST TAKE OTHER CORRECTIVE ACTIONS, INCLUDING SANCTIONS, WHEN APPROPRIATE.

FUTURE ACTIVITIES

WE ARE EXTREMELY PLEASED WITH THE SUCCESS OF THE PROSPECTIVE PAYMENT SYSTEM AND THE PERFORMANCE OF PEER REVIEW ORGANIZATIONS IN ASSURING THAT HIGH QUALITY CARE IS MAINTAINED. HOWEVER, WE KNOW WE MUST CONTINUE OUR EFFORTS TO REDIRECT OUR HEALTH CARE SYSTEM TO PROVIDE A MORE COMPETITIVE ARENA PROMOTING GREATER BENEFICIARY ACCESS TO MORE COST-EFFECTIVE CARE. AT THE SAME TIME WE MUST ADJUST AND REFINE THE PPS SO THAT IT IS UP TO DATE AND CAPABLE OF RESPONDING TO THE EVOLVING HEALTH MARKETPLACE. AND FINALLY, WE MUST CONTINUE OUR RESEARCH TO EFFECT PAYMENT REFORMS AND PROVIDE BETTER WAYS TO DELIVER HEALTH CARE. LET ME BRIEFLY DESCRIBE SOME OF OUR ONGOING ACTIVITIES IN THESE AREAS.

WE BELIEVE THAT CAPITATION HAS TERRIFIC POTENTIAL FOR IMPROVING COMPETITION AND GREATER ACCESS TO COST EFFECTIVE HEALTH CARE. CAPITATED HEALTH CARE PROGRAMS HAVE THE DISTINCT ADVANTAGES OF GENERALLY INCLUDING MORE LOCAL DECISION MAKING IN STRUCTURING PLANS, PROVIDING ADDITIONAL BENEFITS OVER THE MANDATED PACKAGE, AND DELIVERING CARE MORE EFFICIENTLY AND SAVING MONEY WHILE DOING SO.

CERTAINLY WE ARE SEEING A STRONG, POSITIVE RESPONSE TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND COMPETITIVE MEDICAL PLANS (CMPS). AS YOU KNOW, MEDICARE CAN NOW CONTRACT WITH CMPS AND HMOS ON A RISK BASIS. REIMBURSEMENT UNDER RISK CONTRACTS IS AT 95 PERCENT OF THE USUAL COST OF SERVICES. WE CONSIDER THESE CONTRACTS ATTRACTIVE FOR BOTH BENEFICIARIES AND THE MEDICARE PROGRAM. TO DATE, 65 RISK CONTRACTS HAVE BEEN AWARDED AND ABOUT 365,000 BENEFICIARIES HAVE ENROLLED IN THESE HEALTH CARE PLANS. THESE PLANS OFFER OUR BENEFICIARIES AN ALTERNATIVE TO THE TRADITIONAL FEE-FOR-SERVICE SYSTEM. BENEFICIARIES WILL BE FREE TO CHOOSE BETWEEN WHAT WE BELIEVE WILL BE AN INCREASING NUMBER OF HMOS AND CMPS. AMONG THE INCENTIVES TO JOIN HMOS AND CMPS WILL BE THE ADDITIONAL BENEFITS THESE

PLANS CHOOSE TO PROVIDE OVER THE STANDARD MEDICARE PACKAGE. MOST IMPORTANTLY, SHOULD MEDICARE BENEFICIARIES, FOR WHAT EVER REASON, BECOME UNCOMFORTABLE WITH THEIR HMO OR CMP, THEY HAVE THE RIGHT TO DISENROLL AND REJOIN THE TRADITIONAL FEE-FOR-SERVICE MEDICARE SYSTEM.

WE ARE ALSO CONDUCTING A DEMONSTRATION OF A CAPITATION PROGRAM CALLED A SOCIAL HEALTH MAINTENANCE ORGANIZATION. THE SOCIAL HMO PROVIDES A BROAD RANGE OF ACUTE AND LONG-TERM CARE HEALTH AND SOCIAL SERVICES TO VOLUNTARILY ENROLLED ELDERLY PERSONS FOR A FIXED ANNUAL PREPAID CAPITATION AMOUNT. FOUR SITES (MINNEAPOLIS, MINNESOTA, PORTLAND, OREGON, LONG BEACH, CALIFORNIA, AND BROOKLYN, NEW YORK) ARE NOW PROVIDING SERVICES. THE SOCIAL HMO DEMONSTRATION WILL BE CONDUCTED FOR 42 MONTHS AND WILL BE EVALUATED UNDER A SEPARATE CONTRACT.

FINALLY, I WOULD LIKE TO MENTION THAT WE WILL SOON TRANSMIT TO THE CONGRESS LEGISLATION WHICH WOULD BUILD ON THE CURRENT HMO AND CMP PROVISIONS. THE VOLUNTARY VOUCHER PROPOSAL WOULD EXPAND THE POOL OF PLANS THAT QUALIFY FOR CAPITATION PAYMENTS BY ALLOWING MEDICARE BENEFICIARIES THE OPTION OF USING A VOUCHER TO ENROLL IN A WIDER ARRAY OF PRIVATE HEALTH PLANS IN ADDITION TO

THE HMOs AND CMPs. BENEFICIARIES WILL BE ABLE TO SELECT THE PLAN WHICH BEST MEETS THEIR NEEDS. THIS PROPOSAL PROVIDES OPPORTUNITIES FOR BENEFICIARIES TO OBTAIN COST-EFFECTIVE, QUALITY HEALTH CARE AND ENCOURAGES COST AND COVERAGE COMPETITION AMONG HEALTH BENEFIT ORGANIZATIONS. THIS COMPETITION IN THE HEALTH CARE INDUSTRY WILL SERVE TO LOWER OVERALL HEALTH CARE COSTS, THUS BENEFITING ALL HEALTH CARE RECIPIENTS AND ENSURING THE FUTURE WELL-BEING OF THE MEDICARE PROGRAM.

TO MEET THE DEMANDS OF THE CONSTANTLY CHANGING HEALTH CARE MARKETPLACE, WE ARE, OF COURSE, CONTINUING OUR ONGOING ACTIVITIES TO REFINE THE PROSPECTIVE PAYMENT SYSTEM. AS I MENTIONED EARLIER, WE HAVE ALREADY MODIFIED THE WAGE INDEX USED TO ADJUST THE LABOR PORTION OF THE DRG RATES. WE ARE ALSO STUDYING OTHER REFINEMENTS SUCH AS ADJUSTING THE RATES TO ACCOUNT FOR SEVERITY OF ILLNESS, AND ARE INVOLVED IN A COMPREHENSIVE RESEARCH EFFORT TO DETERMINE HOW TO RECOGNIZE DIFFERENCES IN SEVERITY AMONG PATIENTS WITH SIMILAR DIAGNOSES. WE ARE ALSO INVESTIGATING HOW TO DEAL EQUITABLY WITH RURAL HOSPITALS WHICH COMPETE WITH CLOSELY NEIGHBORING HOSPITALS IN URBAN AREAS.

ANOTHER ISSUE OF CONCERN IS APPROPRIATE PAYMENT TO HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW INCOME AND MEDICARE PATIENTS. BOTH THE HOUSE AND SENATE COMMITTEES HAVE APPROVED GIVING EXTRA PAYMENTS TO THESE HOSPITALS. WE BELIEVE THAT MAKING SUCH AN ADJUSTMENT IS PREMATURE AT THIS TIME BECAUSE OF THE UNRELIABILITY OF AVAILABLE DATA. THE RELATIONSHIP BETWEEN MEDICARE COSTS AND LOW-INCOME PATIENTS IS STILL NOT WELL UNDERSTOOD. WE DO, HOWEVER, HAVE AN EXTENSIVE RESEARCH EFFORT UNDERWAY WHICH SHOULD ENABLE US TO CONSTRUCT A BETTER PROXY THAN IS CURRENTLY AVAILABLE TO DEFINE DISPROPORTIONATE SHARE. IN THE MEANTIME, ARBITRARILY SELECTING A DEFINITION AND REWARDING ONLY THOSE HOSPITALS WHICH FIT THAT DEFINITION WOULD CREATE A WHOLE NEW SET OF WINNERS AND LOSERS.

WE ARE ALSO STUDYING OTHER AREAS OF THE PROSPECTIVE PAYMENT SYSTEM, AS YOU KNOW, TO INTEGRATE CAPITAL PAYMENTS, EXEMPT FACILITIES AND MEDICAL EDUCATION COSTS INTO THE OVERALL SYSTEM. ALSO, AS ONE ASPECT OF OUR COMPREHENSIVE EFFORT TO REFORM PAYMENTS TO PHYSICIANS, WE ARE INVESTIGATING METHODS OF INCLUDING PAYMENT FOR PHYSICIANS SERVICES PROVIDED TO HOSPITAL PATIENTS IN THE DRG RATE.

WE ARE ALSO PLANNING TO RESEARCH IMPROVED METHODS TO PAY FOR HIGH UTILIZATION ITEMS SUCH AS LABORATORY SERVICES AND DURABLE MEDICAL EQUIPMENT (DME). PAYMENT FOR THESE ITEMS AND SERVICES HAVE BEEN SUBJECT TO CONSIDERABLE DISCUSSION AND REFORMING OUR REIMBURSEMENT METHODOLOGY IS ONE AVENUE WE ARE PURSUING. WE HAVE RECENTLY AWARDED A CONTRACT FOR THE DESIGN OF A COMPETITIVE BIDDING SYSTEM FOR LABORATORY SERVICES AND ARE INVESTIGATING A SIMILAR APPROACH FOR STUDYING DME REIMBURSEMENT.

OUR STUDIES OF ALTERNATIVE PAYMENT METHODOLOGIES EXTEND TO POST-HOSPITAL CARE FOR SERVICES PROVIDED BY SKILLED NURSING FACILITIES (SNFS) AND HOME HEALTH AGENCIES (HHAS). CURRENTLY, WE HAVE CONTRACTORS EXAMINING RESOURCE UTILIZATION GROUPINGS IN ORDER TO DEVELOP A PROSPECTIVE PAYMENT CLASSIFICATION METHODOLOGY FOR SNFS. WE HAVE ALREADY EXAMINED VARIOUS METHODOLOGIES FOR PROSPECTIVELY PAYING HHAS AND ARE CONSIDERING HOW BEST TO PROCEED IN THIS AREA.

FINALLY, WE ARE CONDUCTING OTHER SIGNIFICANT DEMONSTRATIONS TO TEST NEW DELIVERY SYSTEMS. FOR EXAMPLE, TO IMPROVE OUR ABILITY TO TARGET PATIENTS FOR WHOM EXPANDED HOME HEALTH CARE SERVICES WILL TRULY SUBSTITUTE FOR INSTITUTIONAL CARE, THE DEPARTMENT

CONDUCTED THE NATIONAL CHANNELING DEMONSTRATION. CONDUCTED IN 10 SITES THE CHANNELING DEMONSTRATION WAS DESIGNED TO DETERMINE WHETHER THE LONG-TERM CARE NEEDS OF ELDERLY IMPAIRED PERSONS CAN BE MET IN A COST-EFFECTIVE WAY THROUGH A COMMUNITY-BASED SYSTEM OF CARE ASSESSMENT, CARE PLANNING AND CARE MANAGEMENT. THE PROJECT COMBINED INNOVATIVE APPROACHES TO THE ORGANIZATION AND DELIVERY OF SERVICES WITH BROADER SERVICE BENEFIT PACKAGES. THE DEMONSTRATION IS NOW BEING EVALUATED AND THE FINAL REPORT WILL BE RECEIVED IN 1986.

CONCLUSION

IN CONCLUSION, WE BELIEVE THAT THE MEDICARE PROSPECTIVE PAYMENT SYSTEM TOGETHER WITH OTHER COMPETITIVE REFORMS IMPLEMENTED IN THE HEALTH MARKETPLACE AND THE OVERALL DECLINE IN INFLATION, HAVE CONTRIBUTED SIGNIFICANTLY TO SLOWING THE RATE OF INCREASE IN THE COST OF THE MEDICARE PROGRAM AND HAS PROLONGED ITS FINANCIAL VIABILITY. OUR RESEARCH AND DEMONSTRATION EFFORTS WILL FURTHER INSURE OUR CAPABILITY TO REACT TO CHANGES IN THE MARKETPLACE AND IMPLEMENT NEW, IMPROVED PROCEDURES FOR DELIVERING AND PAYING FOR HEALTH CARE.

THROUGH OUR EFFORTS TO REFORM PAYMENT, PROVIDE ALTERNATIVE HEALTH CARE PROGRAMS AND ENCOURAGE GREATER CONSUMER PARTICIPATION IN CHOOSING THEIR HEALTH CARE, WE CONTINUE OUR COMMITMENT TO PROTECT THE INTEGRITY OF THE MEDICARE TRUST FUND AND ASSURE THAT MEDICARE WILL BE AVAILABLE TO MEET THE FUTURE HEALTH CARE NEEDS OF OUR NATIONS ELDERLY AND DISABLED.

I LOOK FORWARD TO AN ONGOING DIALOGUE WITH THIS TASK FORCE AS WE CONTINUE TO INVESTIGATE THE IMPACT OF PPS AND REFINE THE SYSTEM. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Mr. FROST. I have a number of questions, and I am sure that Mr. MacKay does, too. Let me start. I am curious, do you have any indication, or any feeling at this point as to what your position will be in the fiscal year 1987 budget on the question of the increase in the DRG rates?

Mr. HADDOW. As I mentioned in the prepared statement, the DRG payment freeze that we are advocating is——

Mr. FROST. For 1986?

Mr. HADDOW. For 1986—is justified based on the methodology that drove us to the figure which justifies actually decreasing the payment rates by 4.42 percent.

I think it would be premature at this point to make any speculation as to what that adjustment would be in fiscal year 1987. If we see the same competitive pressures being exerted in the health care marketplace, it would not surprise us to see that there is a lack of justification for expanding those payments significantly in fiscal year 1987.

Mr. FROST. Of course the reconciliation legislation out of the Ways and Means Committee has a 1-percent increase for fiscal year 1986.

Mr. HADDOW. Yes, it does.

Mr. FROST. And the administration is opposed to even a 1-percent increase in 1986; is that correct?

Mr. HADDOW. That's correct. Based on the formula which justifies an actual decrease, we felt that it was a fair proposal to continue the rates in fiscal year 1985 bases. And we are opposed to both the 1 percent proposed by the House and the one-half percent by the Senate.

Mr. FROST. Can we assume that you would be opposed to a 1-percent, or even a 1.5-percent increase in fiscal year 1987 based upon your current thinking?

Mr. HADDOW. At this point I would say that is a justified assumption. But again, it would be premature to make a definitive statement as to what our proposal will be.

We are particularly concerned that we are fair to the hospitals. And looking at the revenue projections we have been given related to past performance, and the data submitted by the hospital associations themselves, we see no justification for tinkering with the system to try to save a hospital system that appears to be quite healthy.

And certainly our reimbursement rates are fair. We know that we easily could have taken a justified position of reducing the rates this year. We simply chose not to do so.

Mr. FROST. Now the Prospective Payment Assessment Commission, in its April 1985 report, recommended a 1.5-percent increase. And, of course, they are the agency which has been charged with monitoring the implementation of the prospective payment system. Where did they go astray? What was wrong with their recommendation?

Mr. HADDOW. Well we, of course, appreciate the work that the Commission is doing. On the other hand, we believe that the formula which we have outlined, on which they apparently do not agree with us, is fully justified. Had they accepted our analysis of it, they would have come to the same conclusions we did, that in fact a reduction in the rates would have been justified.

It is not clear to me on what basis they would advocate a 1.5-percent increase.

Mr. FROST. Well, of course, this was a report in April.

Mr. HADDOW. Right; I say it is not clear to me. I have seen the report. It is not clear to me why they would feel justified, given the clear statistical evidence that indicates that a reduction would be justified.

Mr. FROST. I would like to pursue it. They made another recommendation. Recommended an adjustment in payments for hospitals which serve a disproportionate share of low-income patients, something which the Ways and Means Committee has provided for, and which the administration opposes. And, of course, in your own statement on page 19—this was a question I was raising with Mr. Waxman earlier—you state that the relationship between Medicare costs and low-income patients is still not well understood. And that this type of an adjustment is premature. Could you elaborate on that?

Mr. HADDOW. Yes; we are very concerned about the disproportionate share issue. Our concern stems from a desire on our part that we really treat the hospitals fairly, as well as those beneficiaries who seek medical care services. And, if we don't take a rational position on this, obviously it is going to create some problems for hospitals who are in distress.

We just don't believe that it is appropriate at this time to make a guess about how we reimburse for disproportionate share, primarily because to do so will affect dramatically hospitals within the system who, if we use an imprecise measurement device, will suffer because of it.

We believe that a disproportionate share adjustment ought to be given to those hospitals who justifiably need it, and not be given as a windfall to those who do not.

Lacking an adequate measurement device, which we are working to refine and perfect for presentation to this committee and to the Congress, we don't think it is appropriate at this time to make a wild guess about how you adjust for disproportionate share.

Mr. **Frost**. Of course, this was provided for in law several years ago. This is not something that is brand new. It simply never has been implemented. The administration has had several years to develop an appropriate definition. Why has it taken so long?

Mr. **Haddow**. Well, I have been very concerned in reviewing the previous testimony of my predecessor and the interest that Congress has shown about the length of time it takes for reports out of HCFA. And I can assure you in the broad issue that we are going to work to refine our timeliness in getting reports to the Congress.

However, in this specific case we first started out with an analysis of the methodology we thought would work. It was only after we had completed a study of the first proxy that it was clear that the winners and losers in that proxy that we used to determine which hospitals are affected by disproportionate share, really didn't make any sense when you started to apply the methodology to the real-world situation.

And so we found quickly that the effort that we had undertaken, that took a considerable amount of time, simply wasn't going to give us an answer that was acceptable in really targeting which hospitals needed the help on the disproportionate share analysis.

Mr. **Frost**. Do you reject the concept of the 15-percent criteria of those hospitals that treat more than *x* percent, whether it be 15 percent or some other percent of elderly and low-income patients, that they would then be eligible for a disproportionate share formula?

Mr. **Haddow**. As I mentioned earlier, we think that the proxy that is used to make that determination, and the formula that would compute for some adjustment for disproportionate shares, is not accurate. And that is why we are embarking upon a study that specifically looks at a crossover between low-income Medicare individuals, beneficiaries, and Medicaid beneficiaries, rather than just using Medicaid.

Because if you use Medicaid alone as your proxy, you are going to find that in a State like Texas, which doesn't have as broad a benefit package as Massachusetts, for example, the hospitals are hurt significantly more and Massachusetts rewarded, not because there is any greater need for adjustments for disproportionate share, but because the formula that we applied is imperfect, and because we rely upon States' discretion to offer certain kinds of benefit packages as a part of their discretionary part of the Medicaid service.

It is just not a good measurement device.

Mr. **Frost**. Mr. Haddow, the result of that is that we do nothing. Now you are talking about in relative terms that one State might benefit more than another State under the formula. But currently we are not doing anything.

Mr. **Haddow**. Well, may I state that we believe the present situation accounts for at least a portion of the disproportionate share.

In the first year of the implementation of prospective payment system, all of the costs were built in on the historical data for 75 percent of the hospital specific rate. That included a disproportionate share computation.

As we move to 100 percent national rate, even when we hit the 100-percent national rate, there will be a part of that national rate which accounts for the disproportionate share computation that went into the original formula.

In other words, we are already accounting for it based on historical cost data of individual hospitals, and we account for it at the end of the system——

Mr. **Frost**. In the aggregate.

Mr. **Haddow**. In the aggregate.

In terms of how we resolve the problem for individual hospitals, we are moving expeditiously in identifying a good proxy, which we will submit to you as soon as possible so that a rational public policy decision can be made.

In the interim, we are looking at the overall aggregate statistics of hospitals in determining that hospitals are not suffering under this system, and the disproportionate share impact on them is not as great as some people would like to lead us to believe.

Mr. **Frost**. Well, let's be more specific.

How long is it going to take for the administration to come up with an adequate measure so that we can get on with compensation for those hospitals that have a disproportionate share?

Mr. **Haddow**. We have a research effort underway which will allow us to construct that better proxy for low-income admissions that is currently being undertaken. This initiative will examine the poverty population by ZIP Code, using census data, and should result in a reliable percent low-income admissions proxy for every hospital, and make it hospital specific.

We also will have determined, by December of this year the cost of Medicaid crossovers—that is the Medicare low-income beneficiaries of Medicaid whose States buy into the Medicare coverage, to see if these poor Medicare patients' costs are higher than those of other Medicare patients. That might be a more reliable proxy as well.

In March 1986, we will begin compiling the data base from the 1984 hospital costs reports. That is the earliest that will be available to us.

In April 1986, we will take the 1984 PPS cost report data that is ready for analysis, and the data on poverty populations by ZIP Code, which are ready for linkage then with the cost report data. We will be able to do that computation.

In May 1986, we expect that a preliminary definition of disproportionate share and the listing of the hospitals will be prepared for your review.

And then in July 1986, we will have the definition in the hospital listing submitted to you for your final review.

Mr. **Frost**. Now, if I understand the somewhat lengthy response that you have just given, that if we chose to do so, Congress certainly could provide a disproportionate share figure in the fiscal

1987 budget. Because what you have told me is that all this will be complete before the beginning of fiscal year 1987, October 1, 1986. Is that correct?

Mr. HADDOW. That's correct.

Mr. FROST. And you would not oppose us providing disproportionate share compensation as a part of the 1987 fiscal year budget?

Mr. HADDOW. If the committee in its wisdom accepted the administration proposal, we would not oppose it, no.

Mr. FROST. Now I am not sure that I understand what you just said. Could you state that another way?

Mr. HADDOW. Well, you said that Congress can actually take this action.

We respect the fact that it can in the 1987 budget, we hope that when the final decision is made about the disproportionate share adjustment in fiscal year 1987 budget, that it is done ,with a full recognition of the administration's results of the studies that we give you, and that you would take cognizance of our recommendation on what that computation should be.

It may not be in sync with what some members of the committee would feel that it should be.

Mr. FROST. Well, assuming that we are going to be talking to each other about that question, how it should be implemented, that the administration is not going to oppose a disproportionate share adjustment in the fiscal year 1987 budget. Is that correct?

Mr. HADDOW. Well, what I am suggesting is that once we have been able to identify what the good proxy is, that that should then drive the recommendations we would make on disproportionate share.

It may be that this problem is nonexistent.

That would not be palatable to some folks who feel that it is. And it would be premature to make a judgment that we are going to support a disproportionate share computation if in fact the numbers in the studies don't reflect that it is needed.

Mr. FROST. Do you anticipate that your study is going to prove that there is no problem?

Mr. HADDOW. No; I don't anticipate anything.

I have seen enough of the studies that have been generated, both by the Congressional Budget Office and our actuaries, that I would hesitate to predict with any degree of reliability what either one was going to say.

Mr. FROST. We will be hearing later on in these hearings from the administrator of Parkland Hospital in Dallas, TX, a city that I represent. That hospital treats a significant number of individuals who would fall within this definition, and I would be interested—I will have a few specific questions for the administrator of that hospital. And I have a feeling that he would disagree that the problem doesn't exist and that you cannot measure hospitals that treat a disproportionate share.

Mr. HADDOW. I don't disagree that he probably will take a different position. But the Medicaid proxy which is being contemplated as the basis for disproportionate share adjustment this year is not going to help that administrator in Texas. In fact, it may hurt him.

Mr. **Frost**. I do want to give Mr. MacKay time to ask some questions. I have one or two other matters I would like to cover with you. I will come back. Mr. MacKay.

Mr. **Haddow**. Thank you.

Mr. **MacKay**. Now, as I understand it, if there is in fact a disproportionate cost and we do nothing about it, then there is a disproportionate share going to the hospitals that least need it now. Is that not correct?

Mr. **Haddow**. The prospective payment system is based on averages, of course. And when we made the computation of what the hospital specific rates were, it was based on historical cost data which would have included an expenditure for disproportionate share cases.

That rate, of course, on a hospital specific basis also became a part of the national rate.

So, there is a baseline formula that inures to the benefit of all hospitals for disproportionate share, even when we get to 100 percent national rate.

There are different classes of hospitals that have a larger disproportionate share problem than others. And what we are most concerned about is that whatever system we develop that allows for a disproportionate share adjustment, that it is done fairly and equitably so as not just to create a new set of winners and losers in the system, since they are sharing the money that is in the pot.

And we don't think that a hospital ought to be rewarded if it doesn't justifiably need it. And that is what the Medicaid proxy does. It, in a very unreliable way, rewards hospitals that may not deserve it, and penalizes those that need the adjustment.

Mr. **MacKay**. I'm not able to talk about these technical items with the same degree of certainty that you are. Let me put it the way I am comfortable, and then get you to respond.

I could name five hospitals in Florida—and there would be 90 percent agreement in the State of Florida among laymen, medical professionals, and hospital administrators that I was right—that are carrying a disproportionate share of the cost of elderly poor, and that in Florida the system is unfair in the sense that it doesn't recognize it. Mr. Frost can do that in Texas.

Every person who has any understanding in his or her individual state can do the same thing.

It is incredible to me that you are saying we are going to pretend that the system is not now disproportionately rewarding the hospitals that aren't bearing the burden, and we are not going to do anything about that until we can accurately measure the change.

What about just setting it at a low enough figure so you know it is not overrewarding anyone outrageously and going ahead?

I mean, in some ways you are saying to me that I should pretend that I don't know these realities exist. Jackson Memorial Hospital in Miami, FL, is carrying a hugely disproportionate share. Shands Teaching Hospital, which is the University of Florida's teaching hospital, the General Hospital in Tampa, and the big downtown hospital in Jacksonville, FL, clearly are disproportionate share hospitals.

And you can worry about the esoteric ways of measuring that all you want to, but it is discrediting the whole system to say we are going to put it off for another year or two until we can come up with something that is totally accurate.

Mr. HADDOW. I don't suggest that we pretend that the problem doesn't exist. But I think that the same point applies in terms of the proxy that we use as the baseline for the formula that is adopted, as to how you adjust the disproportionate share.

Your hospital in Florida won't be any better served by a Medicaid proxy. And it will unfairly penalize it and inure to the benefit of some other hospital in some other State where they have a broader range of Medicaid services.

And that is just plain unfair. And it took us a while to find that out. But we now are moving quickly toward a better, more refined proxy that will allow us to more accurately depict the performance of hospitals in disproportionate share cases. And we are asking until the middle of next year in advance of the fiscal year 1987 rates that will be computed, for that opportunity to do so. And in the interim, we still have an adjustment for disproportionate share which is built into the computed rate. And we see overall in the aggregate that the hospitals are doing very well.

And teaching hospitals, which you have identified, certainly have had a windfall in the indirect medical costs that they have enjoyed for several years.

So, we think that in the aggregate the system has had a buffer to protect itself. And we want to be fair to your hospitals as well in the right proxy that is applied to disproportionate share.

Mr. MACKAY. Do you see any policy justification in having a proxy that provides an incentive to State legislatures to understand the workings of Medicaid in a more reasonable fashion?

For instance, the hospitals in Florida and the medical profession in Florida are now arguing to the legislature that they should broaden the Medicaid Program for the very reason that you are talking about.

It makes more sense to have the Federal Government paying part of the cost, than to pretend the costs don't exist and have local taxpayers pick up the burden.

All told, would it not be better to have a proxy that rewards those States that have an adequate Medicaid Program?

Mr. HADDOW. We don't think the Medicaid proxy is a good one. And if the outcome is that it encourages States to expand Medicaid services when the real decision about Medicaid services ought to be based on local needs, there should not be an artificial incentive provided the State legislatures to expand services merely to increase the Medicare reimbursement that would be provided under a disproportionate share adjustment. That would be unfortunate.

Having served in a State legislature myself, I can tell you that it would be easy to get railroaded into that position. But the outcome would be increased cost for both the State and the Federal Government, and it wouldn't address the question fairly or accurately as to what hospitals served disproportionate share.

So, I guess my point is we just need a little time in order to come up with a good proxy. We think we have now squeezed down the ones that don't work; we know that Medicaid is not a good one, and we hope that the Congress will see fit to defer in the implementation of disproportionate share calculation until fiscal year 1987 when we have the studies done and we can target where that disproportionate share computation ought to go.

Mr. **Frost**. Mr. Haddow, I want to ask you about your testimony on the voucher system. I am not sure that I understand exactly what you are saying. These vouchers would be used for what portion of the current Medicare system? Are you talking about both the hospital part and the physician's part, part B or, are you only talking about part A? How far does the voucher concept go?

Mr. **Haddow**. Our goal in the administration's program is to, of course, encourage competition to go to a capitated system. We see great advantage to a capitated system.

The voucher program would apply to both. The beneficiary would be able to seek out a provider, and that provider would, in the competitive marketplace, have to compete for those beneficiaries and offer a range of services that, as we have seen in the HMO's that now enroll Medicare beneficiaries, would have expanded benefits in order to attract enrollees.

And so it would apply to both, and it would be the responsibility of the carrier to provide those services based on the voucher having been presented to them for the period of time of enrollment. And, we allow for the opting out to the fee-for-service side if the beneficiary determines it is in their interest to not participate in the future.

We think the voucher concept, however, has great advantages to the beneficiary without any additional costs to the Federal Government.

Mr. **Frost**. How soon do you expect to make an actual legislative recommendation on this?

Mr. **Haddow**. Well, we intend to submit to the Congress very shortly a first draft of our voucher proposal for your review.

Mr. **Frost**. To be effective when?

Mr. **Haddow**. Well, hopefully, as soon as possible at the discretion of the Congress, of course.

We are very concerned that we move toward a more competitive marketplace as soon as possible because that, of course, has benefits to the trust fund.

Mr. **Frost**. There have been reports in the media about the question of extending the DRG concept to physicians. Is that something that you anticipate making a recommendation on any time soon?

Mr. **Haddow**. Yes. We have instructions from the Congress to submit a report on physician DRG's. As we analyze the variety of options that are currently available to us for physician reimbursement, we recognize the significant problem of Medicare part B payments to physicians increasing at astronomical rates and recognize the need for something to be done.

We have expanded our review beyond just physician DRG's, principally because any DRG program for physician reimbursement would exclude, by nature, the out-of-hospital care that is given by physicians which accounts for about 36 percent of the outlays under part B for physician services.

It is no secret that we have been reviewing other options that perhaps could be considered by the Congress, including a national fee schedule that could be set. And then at an appropriate time when all of the studies are done—and we do have one in the field—

to apply a relative value scale, that could account for specialties, for the overhead cost for practice and that sort of thing.

So, we will be presenting some options for the consideration of the Congress, that we think expand beyond the original request that the Congress made, but actually move into a situation where we are responding to the specific marketplace needs. In the interim we are asking for the extension of the freeze through fiscal year 1987.

Mr. FROST. Through 1987?

Mr. HADDOW. I'm sorry, through 1986, the beginning of 1987.

Mr. FROST. Do you anticipate as a part of your 1987 budget submission to Congress, that you would be making a recommendation on a physician's DRG system?

Mr. HADDOW. To some form of physician reimbursement that throws out the present system which we find to be inadequate, yes.

Mr. FROST. So you do expect a sharp departure from the present physician reimbursement system in some form to be a part of your fiscal 1987 budget submission?

Mr. HADDOW. It would be surprising at this point for us to ask the Congress to continue the present reimbursement formula in fiscal year 1987.

Mr. FROST. It will be interesting when that recommendation is made. Do you expect that this would in fact effect significant savings over the current system?

Mr. HADDOW. We expect that the rate of growth in expenditures will be significantly changed and depressed, hopefully.

The current system builds on inflation. It takes last year's rate that has been inflated, and inflates it further without any recognition of changes in the patterns of practice, increases in technology advance, of productivity gains. We don't think it is a good system right now. And so obviously we intend that any proposal we would make would achieve savings without diminishment of the quality of care that beneficiaries receive.

Mr. FROST. Let me ask you one other question.

In recommending that there be a freeze in DRG reimbursement rates, DRG rates this year, fiscal year 1986, were you primarily concerned about increasing the surplus in the hospital insurance trust fund, or were you primarily concerned about the effect that this would have on the overall budget deficit?

What was the origin of this request? Were you looking to the savings that this could effect to reduce the total budget deficit, or were you concerned about the health of the hospital insurance trust fund?

Mr. HADDOW. Well, as you know I am the Acting Administrator, and wasn't involved in the fine detail of the motivations for the concern.

I suspect that—and clearly it is something I embrace—that we are concerned about the runaway costs that are depleting the trust funds in the physician side, and certainly controls need to be implemented. And there is ample room for this to occur.

We are committed, however, to pay the appropriate amount for the care that is necessary. And if it is justified, if we are seeing physician inflation each year of 9 percent——

Mr. **Frost**. I'm talking about the hospital insurance trust fund, not physicians.

Mr. **Haddow**. Well, on the hospital side the same thing. I think our primary goal is to pay only what is appropriate, not to pay just on a cost-reimbursement system that didn't really establish any incentives for competition.

Mr. **Frost**. But Dr. Penner's testimony—and I referred to this during his appearance—his statement shows that in fiscal year 1986, even if there had been full inflation for DRG's, that there would have been a $10 billion surplus of income over outlays.

And I am not sure, I thought I just heard you say that you were concerned about the runaway costs and the deficit or the potential deficit in the trust fund.

It doesn't appear that in 1986, 1987, 1988, or 1989 under Dr. Penner's analysis, that even had we granted full inflation for DRG's, that there would have been any addition—that there would have been any deficit on a current year basis in that trust fund.

Mr. **Haddow**. We don't argue that there would be.

What we are concerned about is the health of the system in the long term. We don't think it is appropriate to take a year-by-year look at the health of the trust fund when you look at the outyears and project in 25 years from now you will be running a $1 trillion deficit.

We think the prudent public policy would be to set into place a system that will prevent that from occurring and to the extent possible, insure that the trust funds will not reach those kinds of deficits.

I don't think that the CBO intended that anyone would interpret the calculation of the surplus to indicate that they don't have to do anything. Clearly we all recognize that in the long term we have a significant challenge ahead of us.

Mr. **Frost**. Now you are saying that in the hospital insurance trust fund over a 25-year period, that there will be a $1 trillion deficit?

Mr. **Haddow**. Over 25 years.

Mr. **Frost**. In the hospital insurance trust fund alone?

Mr. **MacKay**. That's correct. That's the actuaries' estimate of the shortfall under current assumptions.

Mr. **Frost**. Current assumptions being full inflation for DRG's?

Mr. **Haddow**. The assumption included a zero increase for next year. So that was factored in. But from that point on it would use the standard assumptions that are available to us.

Mr. **Frost**. Mr. MacKay, do you have any questions?

Mr. **MacKay**. I think I agree with what you are saying. If we have that kind of a problem over a 25-year period, you are not going to solve that by freezing the reimbursement rate. You have got to deal with that in a much more fundamental way.

Our assumption is that you are also looking at other methods which would either reduce costs or find other revenues?

Mr. **Haddow**. We think in the long term that the solution to this is a total movement from a cost-based reimbursement system which we have now started on, to a capitation system which really has all of the elements of competition and allows for the consumer to be the real power in the marketplace.

When we reach that objective, we think that we are going to see significant benefits to the fiscal condition of the trust funds. And that, combined with other refinements as we move along in the system, that will be required, will provide for the long-term stability of the trust funds for the beneficiaries.

Mr. MACKAY. What is your timeframe for that?

Mr. HADDOW. Well, we have started.

The prospective payment system should be allowed to continue to its full cycle of implementation. Beyond that we will have to furnish the studies that will provide for a new physician reimbursement formula; we will provide the voucher program to you; we intend to expand the HMO concept, the CMP's, the competitive medical plans, to expand the choices for beneficiaries; we will look hard at all of the other studies that can be provided for an application of DRG's and skilled nursing facilities at home health agencies.

We are looking at every opportunity to apply competitive principles to a health care delivery system that has been insulated from them for many, many years. And we are ready to take the medicine in order to cure the patient. We think that trust fund will eventually be secure if we are allowed to implement the programs that we laid out for you.

Mr. MACKAY. What is your view of States being allowed waivers to try innovative programs? Variations of channeling, and that kind of thing?

Mr. HADDOW. As long as the waivers are appropriately done, and the States maintain the integrity of it, we welcome them. Because we are interested in any kind of cost-saving mechanism.

It is unfortunate, however, that on some waivers that have been granted to States, with the purpose of demonstrating cost savings, the States haven't played ball very well.

We found in some States where they got a waiver, they enrolled more people than were qualified for the program; they used it as a dumping ground for Medicaid recipients to get funded by Medicare money—that wasn't the intent of the waivers. So, we will be aggressive in enforcing the integrity of the waiver, but welcome opportunities where we can use innovative local approaches to resolve problems, and hope to learn from those waivers where they are effective for implementation on a national basis where it is appropriate.

Mr. MACKAY. You have had now 10 channeling experiments. When will you report on those?

Mr. HADDOW. I'm unfamiliar with the—I'm sorry, 1986.

Mr. MACKAY. Well that is 12 months. I'm just interested in when, during 1986?

Mr. HADDOW. I'm told it will be early on in the year. And I will push to meet that deadline for you, sir.

Mr. MACKAY. It would seem to me that is one of the most promising things that has happened under the Reagan administration. And if you are going to accelerate anything, that would be the place you would accelerate.

What bothers me, representing the State of Florida, is you can solve everything there is to solve under the DRG system, and there is still a major, major problem, which is long-term health care that can't be solved by trying to institutionalize people more efficiently.

It has got to be solved by an effort at deinstitutionalization, case management, use of community resources. And it would seem to me this is one area——

Mr. HADDOW. We share your concerns on that issue.

Mr. MACKAY. Thank you, Mr. Chairman.

Mr. FROST. Mr. Haddow, thank you for appearing today.

Mr. HADDOW. Thank you very much.

Mr. FROST. We appreciated having you with us.

The final witness today is Dr. Donald Young, executive director of the Prospective Payment Assessment Commission.

STATEMENT OF DR. DONALD A. YOUNG, EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Dr. YOUNG. Thank you, Mr. Chairman.

I would like today to present ProPAC's views on the status of the Medicare prospective payment system. I will submit the text of my full testimony for the record and briefly summarize it.

As you are aware, the prospective payment system represents a dramatic departure from the hospital payment system used in the Medicare Program from 1966 to 1983. The cost-based reimbursement system in place prior to PPS lacked incentives to provide care in the most efficient manner or to balance the cost of additional care with expected improvements in health status.

The Medicare prospective payment system is designed to pay hospitals a fixed amount for treatment, based on the patient's diagnosis. Patients are thus classified into diagnosis-related groups. Rates reflecting relative resources used are assigned to each DRG. Average amounts, based on historical hospital costs per case, are combined with the weights to determine the payment.

Over the first 3 years, these average amounts varied by region, urban and rural designations. Adjustments are made to take into account the relatively high cost of teaching hospitals, geographic differences in wages, and cases with extremely high costs or long lengths of stay, the so-called outliers.

Because of the highly technical nature of the system and because it represents such a significant change from past payment practice, the Congress was particularly concerned that the new payment system be carefully monitored, maintained, and updated, and ProPAC was authorized in the statute which enacted PPS.

Since the Commission has not previously appeared before the Budget Committee, I would like to make a few general remarks about our responsibilities.

The 15 members of the Commission are appointed by the Director of the Office of Technology Assessment and are assisted by a staff of 25. The basic responsibility of this independent group is to advise the Congress and the Secretary of Health and Human Services in maintaining and updating the PPS. We do this through a series of legally mandated reports and recommendations.

Specifically, we are mandated to provide each year to the Secretary of Health and Human Services recommendations about the appropriate percentage change in the next year's Medicare payments for inpatient hospital care. This is called the update factor.

In addition to recommending an update factor, we are required to consult with and to recommend to the Secretary necessary changes in diagnosis-related groups, including advice about establishing new DRG's and changing the relative weights of the existing DRG's. Recommendations on both of these subjects are delivered by April 1 to the Secretary each year in a report which is publicly available.

We are also required to provide to the Congress an evaluation of the changes made in the PPS by the Secretary through her regulatory process. This report is planned for November of each year, beginning this year.

Finally, we have been asked to provide a report to the Congress, describing our assessment of the impact of the prospective payment system on the American health care system as a whole, which will be completed annually in February, beginning in 1986.

ProPAC sees its role as that of an independent, analytically based organization. The Commission believes that its major contribution to the maintenance and evolution of the maturing PPS is the development of recommendations grounded in quantitative data and analytic reasoning. The Commission is very optimistic about the success of PPS and believes that the basic system is sound.

It appears that the restructured incentives in the system are working to help bring down length of hospital stays and to shift care into more efficient outpatient settings when that is appropriate.

ProPAC is mindful, however, of the need to make improvements in the system. As is true with any new approach, problems do exist, and it is important that solutions to these problems be developed, debated, and implemented.

It is also critical that we analyze the impact of this very complex payment system, because there is still much to learn about its impact on costs and on patient care.

I would like to mention some problem areas that the Commission has been working on. In our April 1985 report, we recommended that an adjustment be made to PPS payments for hospitals which serve a disproportionate share of low-income patients. The Commission sees this as an issue of equitable distribution of prospective payment funds to hospitals.

Following our general recommendation in April, we assembled a technical advisory group to assist in the development of a specific adjustment methodology, and we have made our technical work available to all interested parties. We are pleased to note that both House and Senate committees working on Medicare legislative changes within this year's budget reconciliation process have chosen to include provisions for such an adjustment. We believe a disproportionate share adjustment is necessary and should be included in PPS rates for fiscal year 1986.

A second important problem recently addressed by ProPAC involves the transition to full national payment rates. As you know, PPS was structured to move over a 3-year period from rates based on hospitals' own historical costs to rates based on national average, urban and rural costs.

In July, ProPAC voted to recommend a pause in the movement to full national rates, indicating that the transition should be delayed by 1 year at the 50-50 rate mix. This decision was based on staff analyses which show that continuing the transition as scheduled would result in 40 percent of PPS hospitals receiving payment gains or losses of at least 5 percent between fiscal years 1985 and 1986. Without the transition, less than 10 percent of hospitals would fall into this category.

In addition to this concern about large payment changes, the Commission also based its concern on the fact that other structural problems within PPS, such as the need for disproportionate share adjustment and an improved definition of hospital labor market areas, should be included in the system before the transition proceeds.

Finally, the Commission was concerned that the likelihood of a complete freeze in payment rates, as contained in the Secretary's fiscal year 1986 PPS regulations, would further exacerbate the distributional consequences of the transition changes.

Turning to another area, a particular concern of the Commission shared by this committee has to do with how best to determine the change in payment rates from 1 year to the next. This, of course, has a tremendous impact upon the budget which you must recommend and constitutes one of our major responsibilities.

In the past, changes from year to year have always been increases, usually expressed as an inflationary amount, the so-called "hospital market basket," plus an additional allowance for technological advancement and practice change. We have called this additional allowance the discretionary adjustment factor.

It appears that in the near future we will not be seeing the high rates of inflationary change present during much of the 1970's and early 1980's. Thus the challenge now involves how to quantify and measure the changes underway in health care delivery in order to develop appropriate rates for an adjustment factor to be used in conjunction with the market basket rate of increase.

We believe that there are a number of components which can be examined and which should be used to come to a judgment about the change in rates from year to year. Basically, these components include productivity gains experienced or achievable as hospitals become more efficient; changes in the product produced by the hospital; shifts of care to outpatient settings; factoring in appropriate allowances for technological and scientific advancements; and allowance for the resource requirements of changing case mix and changing patient mix in PPS hospitals.

In addition to these specific components, the Commission is guided by the overall objectives of maintaining quality of care and beneficiary access and enhancing long-term cost-effectiveness in the health care system.

I might note here that our judgments for fiscal year 1986, developed for our April 1985 report to the Secretary, resulted in a recommendation of an increase of approximately 1.5 percent over fiscal year 1985 rates. The Commission's recommendations for fiscal year 1986 basically reflect a judgment and a belief that appropriate, sustained, and necessary technological growth in the health care industry can be achieved in part by savings generated through improvements in hospital productivity.

We believe it is important to set an update factor which encourages continued productivity and efficiency in the delivery of inpatient hospital services, while at the same time allowing hospitals to continue to deliver high quality services to Medicare patients.

We will be pleased to continue our work with this committee as we further refine our thinking and our analysis, for this is a critical subject for both of us.

I would like to turn now to list just briefly a few other ProPAC priorities.

The work which we have underway includes improvements in the measurement of the hospital labor market areas; evaluation and refinement of case mix measurement; improvement in the methods used to account for resources consumed during specific types of hospital stays; system responsiveness to changes in medical practice patterns; payment mechanisms for new or changing technologies; and the effects of PPS on health care delivery, including changes in quality of care and health outcomes.

Mr. Chairman, you asked that I address two other subjects. The first, the indirect teaching adjustment, is a subject about which the Commission has sought to remain generally knowledgeable, but not one on which we have completed detailed analysis and study. Nor has the Commission taken a policy position on the current debate about the level of the adjustment.

The whole area of medical education and the subsidies and cross-subsidies inherent in our third-party payment system is one which deserves careful consideration from policymakers. Currently, we are looking at the impact of PPS on teaching hospitals as a group through our analytic work on DRG's. This is a subject which the Commission would like to consider when some of our current studies are completed and resources are available.

You also asked that we also comment on proposals to establish a uniform fee schedule for physicians who treat Medicare patients. The Commission has not discussed physician reimbursement and does not feel that this subject is appropriate under our legislative mandate. Thus, I will not comment further on it.

In summary, the Prospective Payment Assessment Commission believes that the Medicare prospective payment system generally is working well and having a moderating effect on health care costs. There are many other changes at work in health care delivery and financing, and it may be impossible to ever say with complete certainty the extent to which PPS is responsible for the control of costs. Nevertheless, it is important to understand more fully the functioning and effect of the PPS as it is currently in place and to work to assure that we balance the need to restrain Federal expenditures with the need to maintain Medicare patients' access to high-quality care.

I would be pleased to answer any questions that you or other members of the task force may have.

[Testimony resumes on p. 92.]

[The prepared statement of Dr. Young follows:]

PREPARED STATEMENT OF DR. DONALD A. YOUNG

Mr. Chairman, I am Donald A. Young, M.D., Executive Director of the Prospective Payment Assessment Commission. I want to thank you for giving me the opportunity to present ProPAC's views on the status of the Medicare prospective payment system (PPS).

As you are aware, the prospective payment system represents a dramatic departure from the hospital payment system used in the Medicare program from 1966-1983. That almost 20-year period saw unprecedented increases in national health care spending and hospital costs. It became increasingly clear that a significant portion of those cost increases were due to expanded public and private health insurance coverage, which emphasized inpatient hospital care and frequently, as in the case of Medicare, reimbursed hospitals on the basis of costs. This cost-based reimbursement system lacked incentives to provide care in the most efficient manner or balance the cost of additional care with expected improvements in health status. Thus, after a developmental period of research, design and testing, the prospective payment methology was adopted for the Medicare program in 1983.

PPS DESIGN

The Medicare prospective payment system is designed to pay hospitals a fixed amount for treatment based on the patient's diagnosis. Patients are thus classified into diagnosis related groups (DRGs). Weights, reflecting relative resource use, are assigned to each DRG. Average amounts based on historical hospital costs per case are combined with the weights to determine payment. Over the first three years, these average amounts vary by region and urban and rural designation. Adjustments are made to take into account the relatively high costs of teaching hospitals, geographic differences in wages, and cases with extremely high costs or long lengths of stay (so-called "outliers"). Capital costs and the direct costs of medical education are excluded from PPS.

PROPAC ROLE AND RESPONSIBILITIES

Because of the highly technical nature of the system, and because it represents such a significant change from past payment practice, the Congress was particularly concerned that the new payment system be carefully monitored, maintained and updated, and ProPAC was authorized in the statute which enacted PPS. Since the Commission has not previously appeared before the Budget Committee, I would like to make a few general remarks about our responsibilities.

The 15 members of the Commission, with expertise and experience in health care financing, delivery, and research, are appointed by the Director of the Office of Technology Assessment and assisted by a staff of 25. The basic responsibility of this independent group is to advise the Congress and the Secretary of Health and Human Resources in maintaining and updating the PPS. We do this through a series of legally mandated reports and recommendations.

Specifically, we are mandated to provide each year to the Secretary of Health and Human Services recommendations about the appropriate percentage change in the next year's Medicare payments for inpatient hospital care, called the "update factor." In addition to recommending an update factor, we are required to consult with and recommend to the Secretary necessary changes in diagnosis-related groups (DRGs), including advice about establishing new DRGs and changing the relative weights of the existing DRGs. Recommendations on both of these subjects are delivered by April 1 to the Secretary each year in a report which is publically available. We are also required to provide to the Congress an evaluation of the changes made in the PPS by the Secretary through her regulatory process. This report is planned for November of each year, beginning this year. Finally, we have been asked to provide a report to the Congress describing our assessment of the impact of the prospective payment system on the American health care system as a whole, which will be completed annually in February, beginning in 1986.

The Commission has divided itself into three subcommittees and meets in open public sessions. Last year, in preparation for its first annual April report to the Secretary, the Commission and its subcommittees met in over 25 such sessions to review and analyze information and data on the prospective payment system. Our current analytic work plan includes studies on such diverse subjects as hospital labor market areas and the wage index used in the PPS system; measurement of the hospital product; measurement of case mix and patient mix changes; variations in the intensity of nursing services provided to Medicare patients; diagnostic and procedure coding under PPS; adequate payment within PPS for costly new technologies and for individual devices with extremely high costs; and, quality of care and beneficiary access to care under PPS. Some of our current studies will result in recommendations in the near term; many others will await continued analysis over the next year or two before we are in a position to make clear recommendations.

My point in describing this work to you is to indicate that ProPAC sees its role as that of an independent, analytically based organization. The Commission believes that its major contribution to the maintenance and evolution of the maturing PPS is the development of recommendations grounded in quantitative data and analytic reasoning. Analytic information, must, of course, be tempered with judgment and experience, but the Commission will continue to strive to fulfill a role in which its approach is always to inform itself with the best and most timely information available before making recommendations.

IMPACT OF PPS TO DATE

The Commission is very optimistic about the success of PPS, and believes that the basic system is sound. It appears that the restructured incentives in the system are working to help bring down the length of hospital stays and shift care into more efficient out-patient settings when that is appropriate. ProPAC is mindful, however, of the need to make improvements in the system. As is true with any new approach, problems do exist and it is important that solutions to these problems be developed, debated, and implemented. It is also critical that we analyze the impact of this very complex payment system, for there is still much to learn about its impact on costs and on patient care.

PROBLEMS IN THE PROSPECTIVE PAYMENT SYSTEM

Disproportionate Share Hospitals

The Commission has identified a series of problems which it believes need to be solved in order to make PPS work better. In our April 1985 report, for example, we recommended that an adjustment be made to PPS payments for hospitals which serve a disproportionate share of low income patients. The Commission sees this as an issue of equitable distribution of prospective payment funds to hospitals. Following our general recommendation in April, we assembled a technical advisory group to assist in the development of a specific adjustment methodology, and we have made our more technical work available to all interested parties. We are pleased to note that both House and Senate Committees working on Medicare legislative changes within this year's budget reconciliation process have chosen to include provisions to include such an adjustment. We believe a disproportionate share adjustment is necessary and should be included in PPS rates for Fiscal Year 1986.

Transition to National Rates

A second important problem recently addressed by ProPAC involves the PPS transition to full national payment rates. As you know, PPS was structured to move over a three year period from rates based on a hospital's own historical costs to rates based on national average urban and rural costs. In FY 1984, the first year of operation under PPS, the rate was 75% hospital-specific and 25% regional urban and rural averages. Last year, FY 1985, the rates were determined by a 50/50 split between hospital-specific and national and regional urban-rural rates. For next fiscal year, 1986, the rates are scheduled to be a blend 75% national/regional urban and rural rates, and 25% hospital-specific rates. In fiscal year 1987 payments would be based on 100% national urban and rural rates.

In July, ProPAC voted to recommend a pause in the movement to full national payment rates, suggesting that the transition should be delayed by one year (that is, from October 1986 to October 1987) at the 50/50 rate mix. This decision was based on staff analysis which shows that continuing the transition as scheduled would result in 40% of PPS hospitals receiving payment gains or losses of at least 5% between fiscal years 1985 and 1986. Without the transition, less than 10% of hospitals would fall into this category. In addition to this concern about large payment changes, the Commission also based its concern on the fact that other structural problems within PPS, such as the need for a disproportionate share adjustment and an improved definition of labor market areas, should be included in the system before the transition proceeds. Finally, the Commission was concerned that the likelihood of a complete freeze in payment rates, as contained in the Secretary's FY 1986 PPS regulations, would further exacerbate the distributional consequences of the transition changes.

Discretionary Adjustment Factor

A particular concern of the Commission shared by this Committee has to do with how best to determine the change in payment rates from one year to the next. This, of course, has a tremendous impact upon the budget which you must recommend, and constitutes one of our major responsibilities. In the past, changes from year to year have always been increases, usually expressed as an inflationary amount -- the so-called hospital market basket -- plus an additional allowance for technological advancement and practice change. We have called this additional allowance the discretionaly adjustment factor. In general, the market basket measures inflationary change adequately, and it appears that in the near future we will not be seeing the high rates of inflationary change present during much of the 1970's and early 1980's. Thus the challenge now involves how to quantify and measure the changes underway in health care delivery in order to develop appropriate rates for an adjustment factor to be used in conjunction with the market basket rate of increase.

We believe that there are a number of components which can be examined and which should be used to come to a judgment about the change in rates from year to year. We will be working hard over the next few months, and in the longer term, to carefully define and measure these components. Basically, these components include:

-- productivity gains experienced or achievable as hospitals become more efficient;

-- changes in the product produced by the hospital;

-- shifts of care to outpatient settings,

- factoring in appropriate allowances for technological and scientific advancements;

- allowance for the resource requirements of changing case-mix and changing patient mix in PPS hospitals.

In addition to these specific components, the Commission is guided by the overall objectives of maintaining quality of care and beneficiary access and enhancing long-term cost effectiveness in the health care system.

I might note here that our judgments for FY 1986, developed for our April 1985 report to the Secretary, resulted in a recommendation of an increase of approximately 1.5% over FY 1985 rates. The components of this recommendation include a positive market basket inflation allowance, decreased by 1.5-2% for expected productivity changes in hospitals, and decreased by 1% for changes in the hospital product. An increase of 1.5-2% was allowed to encourage the development of quality-enhancing technologies. Finally, a positive adjustment for real case-mix change and a negative adjustment for coding changes were factored in, to come to the resulting total proposed increase of 1.54%. Although complicated here in description, the Commission's calculation for FY 1986 basically reflects a judgment and belief that appropriate, sustained, and necessary technological growth in the health care industry can be achieved in part by savings generated through improvements in hospital productivity.

We are currently in the process of recruiting a technical advisory group of experts within and outside the government to work with us on the task of defining and quantifying this discretionary adjustment factor. This will be a difficult task, but we believe it is important to set an update factor which encourages continued productivity and efficiency in the delivery of inpatient hospital services while at the same time allows hospitals to continue to deliver high quality services to Medicare patients. We will be pleased to continue to work with the Committee as we further refine our thinking and our analysis, for this is a critical subject for both of us.

Other ProPAC Priorities

I mentioned earlier some of the other analytic work which the Commission has underway. In each of these areas, we have perceived problems which we believe need additional study and analysis. The work which we have underway includes: improvements in the measurement of hospital labor market areas; evaluation and refinement of case-mix measurement; improvement in the methods used to account for resources consumed during specific types of hospital stays; system responsiveness to changes in medical practice patterns, focusing on payment mechnisms for new or changing technologies; and the effects of PPS on health care delivery, including changes in quality of care and health outcomes, changes in types of patients treated in hospitals, and changes in the hospital product.

OTHER POLICY CONCERNS

Mr. Chairman, you asked that I address two other subjects. The first, the indirect teaching adjustment, is a subject about which the Commission has sought to remain generally knowledgeable, but not one on which we have completed detailed study and analysis. Nor has the Commission taken a policy position on the current debate about the level of the adjustment. The whole area of medical education, and the subsidies and cross-subsidies inherent in our third party payment system, is one which deserves careful consideration from policy-makers. Currently, we are looking at the impact of PPS on teaching hospitals as a group through our analytic work on DRGs. This is a subject which the Commission would like to consider further, when some of our current studies are completed and resources are available.

You also asked that we comment on proposals to establish a uniform fee schedule for physicians who treat Medicare patients. Mr. Chairman, the Commission has not discussed physician reimbursement policy, and does not feel that this subject is appropriate under our legislative mandate. Thus, I cannot comment further on this subject.

SUMMARY

Generally, the Prospective Payment Assessment Commission believes that the Medicare PPS system is working well and having a moderating effect on health care costs throughout the system as well as in the Medicare program, by bringing new incentives and pressures to bear on hospitals. There are many other changes at work in health care delivery and financing, and it may be impossible to ever say with complete certainty the extent to which PPS is responsbile for the control of costs. Nevertheless, it is important to understand more fully the functioning and effect of the PPS as it is currently in place, and to work to assure that we balance the need to restrain Federal expenditures with the need to maintain Medicare patients' access to high quality care.

I would be pleased to answer any questions you or other members of the Task Force may have.

Mr. FROST. Dr. Young, I don't know if you were here and heard Mr. Haddow's testimony.

Dr. YOUNG. Yes, I did.

Mr. FROST. Since it was your Commission that recommended in April 1985 that there be an adjustment for hospitals that serve a disproportionate share of low-income patients, what is your reaction to his testimony that that recommendation is premature, and that you simply can't—that we don't have a way of doing that right now?

Dr. YOUNG. The Commission felt very strongly that an adjustment was necessary, was justified, and indeed was very feasible. The weaknesses and the deficiencies of the data base are well known to those who have been involved with this issue.

As part of our process, as I noted in my testimony, we convened a technical advisory group from a variety of organizations and agencies and discussed some of these issues. While the technical people had some disagreements and preferences, I think there was a general feeling that indeed it is feasible. And the analysis that we did dealt with some of the problems and concerns that Mr. Haddow raised.

One of the problems that he stressed was the definition of the Medicare proxy. We are well aware of those problems, and our analysis and recommendation would take into account the Medicare eligibility differences within the States.

We also conducted our analysis looking at a threshold level for such an adjustment to deal with some of the other problems. So the Commission was unanimously of the mind that an adjustment was justified and was feasible.

Mr. FROST. You think HCFA is wrong on this question?

Dr. YOUNG. The Commission feels strongly that an adjustment should be made, and therefore disagrees with the Secretary on that topic, yes.

Mr. FROST. What about the studies that HCFA is doing right now, the things that he outlined that are going to take place during early and mid-1986?

Dr. YOUNG. I have not seen the studies specifically. I have some general awareness of them, and I am generally aware of the objectives and the concern within HCFA about the use of the Medicare data, but I have not seen the details of the studies they currently have underway or the results of a preliminary analysis.

Mr. FROST. Your Commission recommended a 1.5-percent adjustment on DRG's. Congress, at least the Ways and Means Committee, has recommended a 1-percent adjustment.

Assuming that that occurs—that there is a 1-percent adjustment—and also assuming that the administration recommends zero for fiscal year 1987 as a part of their budget, that there not be any adjustment at all, what would be the combined effect of those two actions on hospitals, in your judgment?

Dr. YOUNG. The Commission, when it arrived at its figure, had to balance a number of factors, and obviously the bottomline balance is a judgment. On the one hand, they were very encouraged by the progress that hospitals had made in bringing about increased efficiency. On the other hand, they were concerned that these adjustments not be made too quickly and that there be adequate money in the system to continue to foster high quality care. Particularly, they were concerned about hospitals adopting new technologies and scientific advances. And I think their figure of about 1.5 percent reflects that judgment.

It would be hard to estimate that 1 percent, as opposed to 1½ percent, would have any specific adverse impact, or even that a freeze would have any specific adverse impact. But it was the Commission's judgment that if you were to err at all, you should err in rewarding a system which is working very well. They felt that we should continue to foster high quality care and technological change and advancement. As less money is put into the system, you increase risks that these goals will not be accomplished.

Mr. FROST. What about the uneven effect of the DRG system on hospitals? The studies that I've seen and have been able to become familiar with indicate that some hospitals, of course, have done very well, have made more money under DRG's, and others have lost money. What is your Commission doing to kind of even that out?

Dr. YOUNG. The concern is particularly with payment amounts and policies that are set that are beyond a hospital's control. The Commission does feel strongly that we should continue with the incentives to promote efficiency, and as part of their update factor, ProPAC did build in a negative factor to encourage continued efficiency. But there is concern about situations where there are policies that are beyond the hospital's control or where there are payment amounts that are different across types of hospitals, and we don't really understand why there are these differences.

One of the reasons that the Commission has recommended a pause in the transition is for those reasons. There are distributional differences across hospitals that the Commission just does not fully understand. The reasons may have to do with the labor market area definitions, the absent of disproportionate share adjustment, the need to better improve the DRG's and better account for severity, or all of those factors or others.

Mr. FROST. But what should Congress do to help those hospitals that are, in fact, losing money under this system and that may be jeopardized by the system?

Dr. YOUNG. We need to know which hospitals are losing money and why they are losing money. What is the reason that they are not able to compete as effectively? Is it a matter of efficiency?

If it is a matter of things like case mix, as I've said, if it's a matter of things beyond their control, then we can recommend and you can make appropriate adjustments that are necessary.

Right now we need a better understanding which of those factors do, indeed, need to be adjusted.

The first one that we identified was the problems with disproportionate share hospitals. We will continue to look at others in this, our second year of existence as a Commission.

Mr. FROST. I would like to ask you, too, about the lack of flexibility under the system. I am thinking about a specific case that happened in my congressional district. One hospital in Grand Prairie, TX, lost more than $100,000 in the treatment of one patient, because of an extraordinary set of circumstances, a self-inflicted gunshot wound for a Medicare patient. He lingered for a long time, for a period of several months, before he died. And the hospital lost, as I said, in excess of $100,000 on this one patient because there was no procedure for making an exception for an extraordinary occurrence.

Is any progress being made on that, that there are some things that simply don't fit into one of these DRG categories and that a hospital could wind up losing an awful lot of money on?

Dr. Young. Yes. Considering that every discharge for every Medicare patient has to be fit into one of 467 or 468 categories, there certainly are discharges that are force fit.

One of the purposes for the outlier policy was to deal with that kind of a problem exactly, and as you are aware, there are both length of stay outliers and cost outliers.

The absence of fine tuning of a measure of severity of illness is also a part of the problem. So we will be looking this year at the issue of case mix, what is called severity, and the outlier policy. Are there improvements, or how can we make improvements to deal with these catastrophic kinds of situations, which again are by and large beyond the hospital's direct control?

I think that that is a problem, and it is particularly a problem for relatively small hospitals, who are unlucky enough to get more than their expected share of these kinds of cases, based on their historical experience.

Mr. Frost. But so far, has there been any system developed for waiving the DRG reimbursement for an extraordinary occurrence, such as the one that I discussed?

Dr. Young. No; I don't believe that there is any mechanism in place for that kind of a situation.

Mr. Frost. Is that something that is being taken seriously or even being contemplated?

Dr. Young. We have not examined it. At one point, I worked for the Health Care Financing Administration. It is always risky to speculate what their reaction might be. I would presume, though, that their reaction would be, as soon as you start putting in place exceptions processes that revolve around judgments, you get yourself into a real problem. And if you could make adjustments in policy that are uniform, and not have to have exceptions, particularly exceptions that require judgments, in the long run you'd be better off.

It is possible that some improvements in the DRG's, plus improvements in outlier policy, will adequately protect the hospitals. But that is speculation at this time.

Mr. Frost. As you point out, that particularly affects a relatively small hospital that is faced with something like this.

Dr. Young. Yes.

Mr. Frost. And it seems awfully inflexible.

I would be interested if you have an opinion on a recommendation, although Dr. Penner did not categorize it as a recommendation, but perhaps as a suggestion that the amount that teaching hospitals be reduced in order to find the money for the disproportionate share adjustment. Does that strike you as something that makes some sense, that we should pursue?

Dr. Young. I thought Dr. Penner handled himself very well on that. I'll try to do as well.

Mr. **Frost**. It was in his testimony.

Dr. **Young**. There is an aspect of case mix measurement where the measurement of the extra costs are already built into the system. So you could say since you have built in extra costs and payments for teaching hospitals, you don't need to build in a full 100 percent amount for disproportionate share. And that's how the logic would go.

The Commission's viewpoint was to break out two separate issues. One was the total amount of funds which would be going into the system as a whole this year. Their recommendation was that that total amount be updated by the 1.5 percent. Having done that, you make a disproportionate share adjustment without adding additional funds.

The Commission did not deal specifically with changing the medical education/teaching adjustment for the purposes of putting in a disproportionate share adjustment, and it would be difficult to do that in any one-on-one way, because the medical education adjustment needs some modifications anyway in most people's minds in terms of the hospitals with very large numbers of interns and residents. That, in itself, is associated with some projected budget savings.

So the answer would be, from a case mix measurement point, certainly a disproportionate share adjustment would help some teaching hospitals and would affect in one way or another the aggregate needs for resources. But that would not translate into necessarily a one-on-one reduction of medical education, because the mix of hospitals that are disproportionate share and the mix that are teaching is not one-on-one. So there is a relationship between the two, but it is very difficult to draw an immediate conclusion about the mathematics of subtracting one from the other.

Mr. **Frost**. Dr. Young, we appreciate your testimony.

We will be back here on October 7 for the second hearing. Our witnesses that day will include representatives from the various types of hospitals that deal with Medicare and the prospective payment system on a daily basis.

Thank you very much for being here. The hearing is adjourned until that time.

[Whereupon, at 3:10 p.m., the hearing adjourned until Monday, October 7, 1985.]

MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

MONDAY, OCTOBER 7, 1985

House of Representatives,
Task Force on Health,
Committee on the Budget,
Washington, DC.

The task force met, pursuant to notice, at 1 o'clock, in room 210, Cannon House Office Building, Hon. Martin Frost (chairman of the task force) presiding.

Mr. Frost. Good afternoon and welcome to this public hearing of the House Budget Committee Task Force on Health. This is the second in a series of three hearings on the Medicare Program, and the prospective payment system. To contain the program's rising costs, and to help insure its future financial stability, Congress made significant changes in the Medicare Program in 1983, establishing a new reimbursment method known as the prospective payment system.

The task force believes that Congress needs to have a full understanding of the effect of these changes before entertaining additional changes that will likely be requested by the administration when it submits its budget for fiscal year 1987. It is the purpose of these hearings to help in this education process, so that informed budget decisions on Medicare can be made.

Last week, several distinguished witnesses appeared before this task force to discuss the prospective payment system and its impact on the Medicare Program. In particular, they gave their assessments of the health of the hospital insurance trust fund as well as their views on the impact of the prospective payment system on hospitals and the quality of care provided to Medicare beneficiaries.

Many of today's witnesses have had firsthand experience as hospital administrators in implementing this new reimbursement system. We have asked them to discuss their experiences with the prospective payment system, as well as to give their views on its impact on their hospitals and on cost containment. We have also asked that they make recommendations for ways to improve the system, including those that might result in additional savings for the Medicare Program.

This information will be of great use to the members of this task force, and will enable us to make recommendations to the Budget Committee for the Medicare function, consistent with the deficit reduction effort, while insuring that Medicare remains financially sound and able to meet the health care needs of millions of Americans.

Today we will be hearing testimony from several representatives from the hospital community including Dr. Ron Anderson, Parkland Memorial Hospital in Dallas, TX; Dr. Charles Buck, Hospital of the University of Pennsylvania in Philadelphia; Ms. Patricia Davis, Humana Hospital in Huntsville, AL; T. Carter Melton, Rockingham Memorial Hospital in Harrisonburg, VA; and Dr. Carl Schramm, Johns Hopkins University in Baltimore, MD.

Originally, Congressman Claude Pepper was scheduled to appear also, but unfortunatly he will not be able to be with us today, but will testify at our third hearing on October 21. I look forward to hearing from our witnesses and I thank each of you for coming.

A little word on how we will proceed. We will first hear from Dr. Ron Anderson, from Parkland, and immediately following his testimony we will hear from Dr. Carl Schramm of Johns Hopkins, who was scheduled to be the final witness but who has a conflict and so we will hear from him second.

Dr. Ron Anderson of Parkland Memorial Hospital is here representing the National Association of Public Hospitals. I am pleased to welcome Dr. Anderson. I have known him for a number of years, have worked closely with him in Dallas, the city that I represent in Congress, and look forward to your testimony.

STATEMENT OF DR. RON J. ANDERSON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARKLAND MEMORIAL HOSPITAL, DALLAS, TX, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, ACCOMPANIED BY LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Dr. ANDERSON. Mr. Chairman, I am pleased to be here today. I am honored to be here to speak on behalf of the patients that we serve, not so much the institutions, and I would like to thank you as my Congressman for your support in Dallas, not only for the public hospitals but for the community health centers. Without your support they would have probably long since failed to survive in our community.

I am the chief executive officer at Parkland Hospital. It is a public county hospital in Texas and the primary teaching hospital for the University of Texas Southwestern Medical School. It currently operates 750 beds and is in the process of adding 204 more beds as an expansion and renovation program, when it comes to fruition. This program was financed in Dallas by general obligation bonds and Parkland, as you see, has a very large operating budget this year totaling approximately $162 million.

In addition to my position at Parkland, I also serve as the chairman of the Texas Board of Health, and I am an executive member of the Texas Health and Human Services Coodinating Council and was honored to be a former member of the Executive Committee of the Statewide Task Force on Indigent Health Care.

In that connection, I did help draft some of the legislation that I feel were reform oriented during the 1985 session of the Texas Legislature. Currently, I now serve as the chairman of the Texas Association of Public and Nonprofit Hospitals. It is a State affiliate of the National Association of Public Hospitals.

Parkland has been an active member of the National Association of Public Hospitals. I am accompanied this afternoon by Larry Gage, president of NAPH. He will help me with our charts.

NAPH consists of 50 public hospitals and hospital systems and serves major referral centers and hospitals of last resort in most of the Nation's large metropolitan areas. We appreciate the opportunity to testify before this committee task force and discuss the impact of Medicare prospective payment system on Parkland and other public hospitals like it.

We would also like to discuss some related issues and convince you, hopefully, that the ripple effect of this legislative reform perhaps has had a larger impact upon our hospitals than any direct effect of reduced reimbursement.

I would like to point out one of the mistakes that is in the executive summary so that it won't be misleading. Under IV, I stated that "Parkland would have lost several million dollars under the first 2 years of DRG's if it had not"—and we need to add "not" before "the direct-indirect payments from Medicare."

Public hospitals in our Nation's major metropolitan areas and other disproportionate share hospitals already have been adversely affected by PPS. Parkland is a relatively busy hospital but it has a small proportion of Medicare and Medicaid patients, only 24 percent of our gross patient revenues.

Parkland writes off 71 percent of its gross patient revenues as charity and bad debts or contractual allowances, and therefore Medicare and Medicaid revenue is indeed critical to the hospital's financial health. Parkland receives approximately 57 percent of its operating revenue from county property taxes, but even this substantial local support does not cover the full cost of uncompensated care. The gap between the tax support and actual cost is closed by revenue from paying patients and nonoperating revenue, particularly interest income.

Indeed, no major public teaching hospital in Texas has sufficient local tax support to fully underwrite the cost of uncompensated care. At Parkland alone, in 1984 this gap was $12 million. When you add in the other six major public teaching hospitals in Texas, the gap rose to $62 million. Parkland has been under DRG's now for 2 full fiscal years. In each of these years, the hospital would have lost $5.1 million, had it not been for the supplementary payments for direct and indirect costs of medical education, $1.2 million and $3.9 million respectively.

The direct cost, though, that we receive from Medicare only represents 17 percent of our total direct cost for house staff expenditures and salaries. This does not address the indirect costs. The State funds a few positions in postgraduate medical education in the public teaching hospitals, but at Parkland this only accounts for 6 percent of our direct cost and no indirect cost is covered. A substantial reduction or elimination of reimbursement for indirect or direct medical education could not be made up without adversely affecting patient services and the quality of the training programs.

At Parkland, as a primary teaching hospital, we employ 370 residents of 500 that usually work in the hospital under the direct supervision of our faculty. It is these resident physicians who primarily provide the lion's share of physicians' services to Parkland patients. Medical education is integrally related to indigent health care.

With Parkland's approximately 29 percent collection rate, the full-time faculty has little ability to generate sufficient professional fee income to supplement salaries toward more indigent services. The medical school administration—and this comes all the way from the regents' State—expects that new charity burdens be met by hospital-paid clinical faculty since increasing charity demands already pull faculty away from educational and research responsibilities.

The State will not fund the medical school to provide faculty sufficient to met our increasing demands for indigent care even though at the present time they render enormous amounts of free care for us. Most NAPH members are also major teaching hospitals and thus have benefited to a certain extent from the indirect medical education adjustments. The CBO and others analysts, however, have clearly found that among major teaching hospitals it is the Government-owned hospitals that have significantly lower operating margins than the private teaching hospitals, and I think will be affected more seriously by the changes that are going toward major reductions.

Most analysts now agree that there are several deficiencies in the present PPS system that contribute to the serious inequities of the system for disproportionate share hospitals, including among other factors the inability of the PPS by itself to adequately account for the following: Differences in the severity of illness for patients in certain DRG's, including patients with multiple diagnoses who require multiple procedures. This list is a partial list of some of the deficiencies.

The cost differences within a single DRG for patients in a public urban teaching hospital can be quite remarkable—range within a DRG—and the difference between hospitals is more remarkable as pointed out in recent articles by Susan Horn's group from Johns Hopkins. Differences in the wage and salary costs incurred by hospitals in inner cities are also not appreciated as opposed to usually lower costs experienced by suburban hospitals. There is also a difference in the case mix among hospitals and particularly among teaching hospitals and nonteaching hospitals.

Extraordinary circumstances experienced by hospitals during or after their PPS base year, such as in the case of the Red Bud Community Hospital, also may require special appeals process and exceptions. The special situation and extra cost experienced by hospitals serving significantly disproportionate share of low-income patients also are not taken into account. The Congress in general, and the members of this committee in particular, clearly understand these inequities and have attempted on several occasions to address these flaws in the PPS.

The mechanisms you have enacted include outright exception of certain hospitals, the indirect and direct teaching adjustments, a general appeals mechanism and the specific adjustment for disproportionate share hospitals. Unfortunately, HHS has refused to permit appeals or exceptions in many of the areas spelled out by Congress as requiring attention.

With regard to disproportionate share hospitals, this includes their refusal to even develop criteria and identify hospitals meeting that criteria as Congress demanded last year. We believe that you must now remedy this refusal by HHS to acknowledge and address PPS inequities, and we feel you can accomplish this first by slowing down the present rate of PPS implementation; second, by paying careful attention to the appeals process generally; and third, by enacting an explicit adjustment for disproportionate share hospitals.

All major participants now agree that metropolitan area public hospitals and other disproportionate share hospitals have higher Medicare costs per case in direct relation to their proportion of low-income patients, as seen in chart No. 2.

The Urban Institute has found that urban hospitals providing a high volume of care to the poor have higher costs per inpatient day and are more likely to have a negative net operating margin than low-volume hospitals.

Chart 3 perhaps more significantly shows that the AHA, CBO and the District of Columbia Hospital Association and internal HCFA studies all demonstrate higher costs are directly related to serving low-income patients. Even though each of these organizations use somewhat different methods and criteria, their studies have come to almost identical conclusions with regard to the relative proportion of the impact on Medicare costs.

It is also important to note, as ProPAC did in April 1985, that regression analysis shows that this impact is clearly separate from the impact of such factors as teaching status, bed size, wage differentials, and urban or rural location. In July 1985, ProPAC once again endorsed these conclusions and reaffirmed its strong position on the needs for this adjustment.

Despite this independent correlation, several observers have suggested that the indirect teaching adjustment is intended to compensate at least in part for disproportionate share status. It is therefore also important to underscore the findings of AHA, AAMC and others that only one-half of all teaching hospitals can be considered disproportionate share providers.

Similarly, we believe there are also disproportionate share hospitals without teaching programs, and some without local tax support who may be in the worst shape of all under the PPS. A clear example of this in Texas would be Mercy Hospital in Laredo, which provides over 35 percent charity and bad debt care, a load that cannot continue without severe repercussions for that border city. We believe we can point to the committee to a number of extra services we provide and costs we incur in four principal areas as possible factors that contribute to these higher costs.

The need to treat sicker patients, special discharge problems in the patients we do serve, extra services needed, and a higher standby cost for many of the community services that are not going to be provided because they are not profitable other than in the public system, should be recognized as legitimate and reimbursable costs.

As ProPAC and almost every other party has urged, implementation of a concrete statutory disproportunate share hospital adjustment is necessary to correct the current inequities in the present system.

This step is essential if Congress chooses to make other reductions in the Medicare Program this year, such as reduction in indirect teaching costs. In that regard, several issuses remain to be addressed. Chart No. 5.

First, how do we accurately and consistently measure the proportion of low-income patients served. Medicaid alone is an inadequate measure of this proportion of low-income patients. This is also shown in chart 6 and in table 1 in your handout, which compares the relative proportion of Medicaid revenues and direct patient or governmental subsidy of major public hospitals in different States, showing clearly the inequitable differences among States in regard to Medicaid coverage.

Texas, for example, has one of the most restrictive Medicaid programs in the country, and consequently at Parkland only approximately 7 percent of patient revenues come from Medicaid.

The proportion of tax-supported care that a hospital provides is a more accurate indicator of disproportionate share than Medicaid alone. We believe that all low-income patients should be counted in determining whether a hospital is a disproportionate provider and not just Medicare or Medicaid patients.

Adding bad debt and charity care to Medicaid in the development of an equation to determine a hospital's relative disproportionality would probably be the most accurate measure, chart 7. However, we acknowledge that the quality of self-reported bad debts and charity care data, such as those found in the AHA's annual report, may be a problem, although we do not believe it is an insoluble one.

Alternatively, we believe the approach adopted by the House Ways and Means Committee measuring Medicaid and Medicare crossover admissions together with a limited appeals process for hospitals whose situation does not accurately describe this approximately solves a number of the problems generated by the use of Medicaid data alone. If this committee chooses to adopt that measure, we strongly recommend that the Medicaid data itself be further corrected for the relative difference between coverage among the various States.

Once you have identified an appropriate measure, what kind of adjustment would we suggest be provided? We believe a continuous or sliding scale adjustment, which would provide a higher adjustment for a more disproportionate share hospital, would be preferable to a single fixed adjustment which might be provided to all hospitals meeting a particular definition. This is the kind of adjustment currently approved by the Ways and Means Committee.

If a sliding scale adjustment is adopted, the question remains as to whether appropriate thresholds for triggering a hospital's initial entitlement can be defined. This can be a national average. It could be some higher level of low-income effort. But put another way, how can hospitals be eligible for such an adjustment?

This is chart 8. You can see that we are talking about a relatively easy skew to identify, and it should be easy enough to identify hospitals who are disproportionate share.

What should be the actual level of the adjustment? For example, the House Ways and Means Committee would increase the Federal portion of the hospital's payment by 0.7 percent for each 1 percent above the national average in a hospital's proportion of low-income patients. What should be the total cost of this adjustment to the Medicare program? We do not have the answers yet to all these questions, but we do not believe answers will be difficult to find if we search for them together in good faith and not allow arbitrary budget targets to cloud our vision.

We would like now to comment on the interim final regulations published by the administration on July 1, 1985, in response to a court order in *Red Bud Hospital* v. *Heckler*. As you may know, the department was turned down in its efforts to get a ninth circuit court of appeals to get an emergency stay of the effect of this order but now has appealed successfully for a stay to the U.S. Supreme Court, Justice Rehnquist. It has the effect of halting these current administrative efforts pending a substantive appeal of the lower court's order. We understand some consideration may be given to enacting a requirement similar to that contained in the July 1 regulation. In summary, we believe that process to be severely deficient in several respects.

No specific criteria is set forward for hospitals seeking to apply for adjustment. No level of adjustment is proposed or methodology established for setting one. No assurance is given that any adjustment could ever be justified. Indeed, quite the opposite impression is given with the pronouncement that the department continues to believe such adjustments are inappropriate. For these reasons, if a case-by-case appeals mechanism such as this one is going to be considered by this committee, we feel a great deal of work would remain to be done.

Up until this point I have confined my remarks to the technical aspects of the Medicare PPS and the direct impact on hospitals like Parkland. This in part is part of the picture. Because the indirect or ripple effect of prospective payment is at least as great if not more significant for our public hospitals.

The prospective payment system has been implemented as the entire hospital industry has become increasingly competitive. In Texas, for example, for-profit hospital corporations now own or manage 50 percent of the hospitals in the State. Many hospitals that were founded as public or not-for-profit hospitals have been acquired by investor-owned chains and are now for-profit hospitals. In other words, to compete in principle, private nonprofit hospitals have backed away from community service and charity care.

As a result, people needing medical care who lack insurance or other resources, the working poor, are often squeezed out of the public sector and shifted to an already overcrowded public hospital system. Parkland's midnight occupancy rates, for example, had been at functional capacity in the 85 percent range, but because of isolation needs such as AIDS, tuberculosis and hepatitis, and because we admit as many patients from the 11 to 7 shift as any other shift in our hospitals, our 7 a.m. census, which is not usually reported as industry standard, often approaches 90 to 95 percent and sometimes above 100 percent capacity, forcing cancellation of needed but elective surgery and medical care.

Furthermore, the patients we are seeing are sicker than in the past. For the first time in Parkland's history we have had to repeatedly implement a diversion policy for critically ill patients needing intensive care because all of our adult intensive care beds are full. This policy, which has never been used in the previous 91 years of the hospital's experience, had to be activated 12 times in August 1985.

Babies born in Parkland have increased at an alarming rate, approximately 12 percent over the previous year, while other hospitals in the area do not report such changes. Some 12,650 babies were born in Parkland's fiscal year 1985, making Parkland the third busiest maternity hospital in the country. The first and second busiest hospitals are Jefferson Davis Hospital in Houston and Los Angeles County Hospital in California. Both are large public hospitals and members of NAPH. The collection rate from maternity patients is much worse than the 29 percent for Parkland's other services, dropping to 17 percent.

Consequently, overall collections for the hospital have declined while the services provided have increased. In that same period overall emergency and outpatient visits have also increased by 50,000 visits per year to over 450,000 total visits per year. In Texas, in public hospitals, ambulatory care is underreimbursed, and we now collect about 10 percent of this cost of care.

Total Parkland admissions have decreased slightly on the medical and surgical services, as they have around the country—more remarkably—as paying patients were actually diverted at times of high census in favor of the indigent patient particularly on the maternity service and the nursery. Elective surgeries for paying patients were shifted to nonprofit hospitals and they were very glad to have these patients since these occupancy rates usually average in the 60 percent or below range. In fact, they court our faculty and the private referral patients away from our institution. The reason our admissions and occupancy rates have stayed up as high as they have relate to the change in patient mix.

The lower collection rate and the increased costs from these changes are having a more profound effect on our budget than any direct change in reimbursement. One reason for the increase in severity of illness we have noticed in our Medicare recipients in Parkland has been a lack of beds which literally precludes admissions for patients who are not critically ill. Some so-called elective admissions in public hospitals are hardly elective. It just means they can be scheduled. Seventy-five percent of our admissions are from the emergency room.

The number of Medicare admissions has actually decreased substantially over the last 2 years and the length of stay for this population in contrast to other Parkland patients has actually increased up to 9.73 days, which is around the national average. This is another indication that admitted Medicare patients are sicker than they were 2 years ago. This phenomenon may be occurring at other hospitals, but certainly from talking to the nurses who work in the home health industry of Dallas, they lament the quicker and sicker discharges that they deal with and the increased acuity of care in their clients as well.

Perhaps one reason the length of stay has not gone down in our Medicare population is because we employ case managers for the elderly. They will not by hospital policy place our patients into no-care zones that you have heard about. In fact, we have made every effort to place them in a continuum of care, but at the same time that their length of stay has increased, the length of stay for other patients who are non-Medicare have dropped from 7.4 days in 1981-82 to 6.3 days in 1984-85.

These same case managers arrange those earlier discharges. At Parkland I feel that any further restrictions in admission criteria which are too stern presently, or reduction in length of stay, could only be accomplished at the patient's expense and would clearly represent explicit rationing of health care.

I am describing the situation where massive amounts of uncompensated care have been shifted to the public hospital over and above its mandated responsibilities. In Dallas, for example, after you consider the local taxes received by this hospital district, we still render 2½ times more charity care per bed than our nonprofit colleagues and 4 times more charity care per bed than our for-profit colleagues. Truly this is disproportionate by any standard.

Mr. FROST. Dr. Anderson, I have looked through the remainder of your testimony. We do have quite a few witnesses today. I think you have addressed in the first half of your testimony some of the major concerns of this task force. I would ask if you could summarize the remainder of your testimony, so that we will have the opportunity for the Members here to ask you some questions, and we do have a number of other witnesses who will be appearing this afternoon.

Dr. ANDERSON. OK, Congressman. I do cover our experience with patient dumping, which is a significant problem for the individual patient but a smaller problem compared to the shift of whole populations of nonpaying patients that we have mentioned. I would like to end by giving you some potential answers for rationale instead of rationing of health care. I think that cost containment and competition discussions have really taken a more prominent role than discussions of access and quality, and I think we can achieve both, and perhaps do so with lower cost, perhaps at the same cost we are now experiencing.

I would hate to lose sight of the fact that good business and good health care policy don't necessarily contradict one another. Importantly, I believe we can take a hard look at ways to work with the public and the nonprofit sector to see if we can't buy the excess capacity in the system. Currently, we don't need to build larger and larger public systems and segregate the poor into an equal but separate system.

That didn't work for education and I doubt that it will work for health care. But there is a situation where you have fixed expense at some point underwritten, and hopefully at that point, maybe with capitated systems, maybe with PPO systems that are dedicated to poverty populations, we could buy the excess capacity like the airline industry sells their empty seats. As long as we could do this fairly enough that we didn't have to cause further cost shifting or hidden taxation on the employer or the paying patient, I think this could be accomplished in such a fashion that we could first of all stabilize the existing safety net, increase access and quality of the care and do so at lower cost.

As the current situation evolves, I think our reimbursement strategies are actually resulting in a situation where in one sector we are becoming more competitive, the hospitals are actually serving fewer people, but as they cut their expenses, they actually can make more money. We need to encourage a reimbursement system that will allow us to maximized the value of fixed expenses in participating health care systems so that we can care for more of those who are disenfranchised at relatively the same cost. I have outlined several of the ideas we have in the public sector.

I would end by saying the National Association of Public Hospitals, Parkland Hospital and our board, feel this can be done in an anti-inflationary way. We would like to see you pay more attention to preventive health care, to the root causes of the problems that cause health care complications for our populations of patients, and we feel that this in time actually will be a more rationale approach to health care than implicit or explicit rationing through a dependency on competitive market forces that cannot address the needs of the poor in this country.

Thank you, sir.

[Testimony resumes on p. 129.]

[The prepared statement of Dr. Anderson, with charts, follows:]

PREPARED STATEMENT OF DR. RON J. ANDERSON

Mr. Chairman, members of the Committee, I am Ron J. Anderson, M.D., President & Chief Executive Officer of Parkland Memorial Hospital, Dallas, Texas. Parkland is the public county hospital for Dallas County, Texas and also the primary teaching hospital for The University of Texas Southwestern Medical School. Parkland currently operates 750 beds and is in the process of adding 204 beds as part of an expansion and renovation program started in 1981 and financed by general obligation bonds. Parkland's operating budget this fiscal year totaled approximately $162 million.

In addition to my position at Parkland, I also serve as Chairman of the Texas Board of Health and as an executive committee member of the Texas Health and Human Service Coordinating Council. I am a former member of the executive committee of the Statewide Task Force on Indigent Health Care in Texas and helped draft the indigent health care reform legislation enacted during the 1985 session of the Texas Legislature. I now serve as Chairman of the Texas Association of Public & Non-Profit Hospitals, a state affiliate of the National Association of Public Hospitals.

Parkland has been an active member of the National Association of Public Hospitals (NAPH), and I am accompanied this morning by Larry S. Gage, President and General Counsel of that organization. The NAPH consists of 50 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's large metropolitan areas.

We appreciate the opportunity to testify before the Committee Task Force to discuss the impact of the Medicare prospective payment system (PPS) on Parkland and other public hospitals and related issues. I hope to convince you that the "Ripple" effect of this legislative reform has had perhaps more impact on our hospitals than the direct effect of reduced reimbursement.

1. PUBLIC HOSPITALS IN OUR NATIONS MAJOR METROPOLITAN AREAS, AND OTHER "DISPROPORTIONATE SHARE" HOSPITALS, ARE ALREADY BEING ADVERSELY AFFECTED BY THE PPS SYSTEM.

   Parkland has a relatively small proportion of Medicare and Medicaid patients--about 24% of gross patient revenues--but since Parkland must write off approximately 71% of gross patient revenues as charity, bad debts and contractual allowances, Medicare and Medicaid revenue is critical to the hospital's financial health.

   Parkland receives approximately 57% of its operating revenue from county property taxes, but even this substantial local support does not cover the full cost of uncompensated care. The gap between tax support and the actual cost of uncompensated care is closed by revenue from paying patients and non-operating revenue, particularly interest income. Indeed, no major public teaching hospital in Texas has sufficient local tax support to fully underwrite the cost of uncompensated care. In 1984 at Parkland alone the gap in county tax support was $12 million, with the gap being an additional $50 million for the other six major public teaching hospitals in Texas.

   Parkland has been under DRGs since October 1, 1983, or for the past two fiscal years. In each of those years, the hospital would have lost $5.1

million dollars, had it not been for the supplementary payments for the direct and indirect costs of medical education, $1.2 and $3.9 million, respectively. The direct payment for house staff cost from Medicare represents 17% of our hospitals total direct expenditures for house staff salaries. The State funds a few positions in post-graduate medical education in public teaching hospitals, accounting for less than 6% of our direct costs. A substantial reduction or elimination of reimbursement for indirect or direct medical education costs could not be made up without adversely affecting patient services and the quality of the training programs at Parkland. As a primary teaching hospital, Parkland employs 370 of over 500 resident physicians who work under the supervision of faculty physicians. It is the resident physicians who provide the lion's share of physician services to Parkland patients. Medical education is integrally related to indigent health care. With Parkland's approximately 29% collection rate, the full-time faculty has little ability to generate sufficient professional fee income to supplement salaries or fund more indigent services. The medical school administration expects new charity service burdens to be met by hospital-paid clinical faculty since the increasing charity demand already pulls faculty away from education and research responsibilities. The State will not fund the medical school to provide faculty sufficient to meet the increasing levels of indigent care at Parkland although they already render enormous amounts of free care.

Most NAPH members are also major teaching hospitals, and thus have benefitted, to a certain extent, from the indirect medical education adjustments. The CBO and other analysts, however, have clearly found that, among major teaching hospitals, government-owned hospitals have significantly lower operating margins than private teaching hospitals and would be much more seriously affected by any major reduction in those payments.

Most analysts now agree that there are several deficiencies in the present PPS methodology that contribute to the serious inequities of the system for disproportionate share hospitals. Those include, among other factors, the inability of the PPS system by itself to adequately account for: (see Chart 1)

I. Differences in severity-of-illness for patients in certain DRGs, including patients with multiple diagnosis or who require multiple procedures. (Horn and Associates (New England Journal of Medicine, 1985, 313:20-4) have shown that, within each DRG, substantial differences are found in the distribution of severity-of-illness in different hospitals. Some hospitals treat larger proportions of severely ill patients and have a wide range of severity within each DRG, but these differences do not always agree with the teaching classification or the Health Care Financing Administration's case-mix index. These findings suggest that patient classification by means of unadjusted DRGs do not adequately reflect severity-of-illness and therefore, prospective payment based on DRGs alone may unfairly and adversely discriminate against certain hospitals represented by our membership.)

2. Differences in the costs incurred by hospitals in inner-cities, as opposed to those in suburbs, including wage differentials and other factors.

3. Differences in case-mix among hospitals, particularly among teaching hospitals.

4. Extraordinary circumstances experienced by hospitals during or after their PPS-base year, which may require appeals or exceptions.

5. The special situation and extra cost experienced by hospitals serving significantly disproportionate numbers of low-income patients.

The Congress in general, and the members of this Committee in particular, clearly understand these inequities, and you have attempted on several occasions to address these flaws in the PPS system. the mechanisms you have enacted include outright exemption of certain hospitals, the indirect and direct teaching adjustments, a general appeals mechanism, and a specific adjustment for "disproportionate share" hospitals. Unfortunately, HHS has refused to permit appeals or exceptions in many of the areas spelled out by the Congress as requiring attention. With regard to disproportionate share hospitals, this includes their refusal to even develop criteria and identify hospitals meeting that criteria, as the Congress demanded last year. We believe you must now remedy this refusal by HHS to acknowledge and address PPS inequities. You can accomplish this: first, by slowing down the present rate of PPS implementation; second, by paying careful attention to the appeals process generally; and third, by enacting an explicit adjustment for disproportionate share hospitals.

II. ALL MAJOR PARTICIPANTS NOW AGREE THAT METROPOLITAN AREA PUBLIC HOSPITALS, AND OTHER "DISPROPORTIONATE SHARE" HOSPITALS, HAVE HIGHER MEDICARE COSTS PER CASE, IN DIRECT RELATION TO THEIR PROPORTION OF LOW-INCOME PATIENTS.

(See Chart 2) The Urban Institute has found that urban hospitals providing a high volume of care to the poor have higher costs per in-patient day, and are more likely to have a negative net operating margin, than low volume hospitals.

(See Chart 3) Perhaps more significantly, AHA, CBO, the District of Columbia Hospital Association and internal HCFA studies all demonstrate that higher Medicare costs are directly related to serving low-income patients. Even though each of these organizations used somewhat different measures and criteria, their studies have come to almost identical conclusions with regard to the relative proportion of the impact on Medicare costs.

It is also important to note, as ProPAC did in April of 1985, that regression analysis has been used to show that this impact is clearly separate from the impact of such factors as teaching status, bed size, wage differentials and urban or rural location. In July 1985, ProPAC once again endorsed these conclusions and reaffirmed its strong position on the need for this adjustment.

Despite this independent correlation, several observers have suggested that the indirect teaching adjustment is intended to compensate, at least in part, for "disproportionate share" status. It is, therefore, also important to underscore the findings of AHA, AAMC and others that only 1/2 of all teaching hospitals can be considered "disproportionate share" providers.

Similarly, we believe there are also disproportionate share hospitals without teaching programs, and some without any local tax support, who may be in the worst shape of all under the PPS system. For Texas, a clear example would be Mercy Hospital in Laredo, which provides over 35% charity and bad debt care, a load that cannot continue without serious repercussions for that border city.

We believe we can point the Committee to a number of extra services we provide and costs we incur in four principle areas, as possible factors contributing to these higher costs. (See Chart 4)

III AS PROPAC AND ALMOST EVERY OTHER PARTY HAS URGED, IMPLEMENTATION OF A CONCRETE STATUTORY "DISPROPORTIONATE SHARE HOSPITAL" ADJUSTMENT IS NECESSARY TO CORRECT CERTAIN INEQUITIES IN THE PRESENT SYSTEM.

This step is essential if Congress chooses to make other reductions in the Medicare Program this year, such as a reduction in the indirect teaching adjustment. In that regard, several issues remain to be addressed: (See Chart 5) First, How do you most accurately and consistently measure the proportion of low-income patients?

1. Medicaid alone is an inadequate measure of the proportion of "low-income patients". (See Chart 6. See also Table 1, which compares the relative proportion of Medicaid revenues and direct governmental subsidies of major public hospitals in different states, showing clearly the inequitable differences among states with regard to Medicaid coverage. Texas, for example, has one of the most restrictive Medicaid programs in the country, and consequently at Parkland, only approximately 7% of patient revenues comes from Medicaid. The proportion of tax-supported

care that a hospital provides is a more accurate indicator of a disproportionate share hospital.

2. We believe that all low-income patients should be counted in determining whether a hospital is a "disproportionate share" provider, and not just Medicare patients, as the higher costs of serving all such patients are usually impossible to separately identify for Medicare patients alone.

3. Adding "bad debt" and "charity care" to Medicaid to develop an equation used to determine a hospital's relative "disproportionality" would probably be the most accurate measure. (See Chart 7). However, we acknowledge that the quality of self-reported bad debt and charity care data, such as in the AHA Annual Report, may be a problem, although we do not believe it is an insoluble one.

4. Alternatively, we believe the approach adopted by the House Ways and Means Committee, measuring Medicaid and Medicare-Medicaid crossover admissions, together with a limited appeals process for hospitals whose situation is not accurately described by this proxy, solves a number of the problems generated by use of Medicaid data alone. If this Committee chooses to adopt that measure, we would recommend that the Medicaid data itself be further corrected for the relative difference in coverage among various state Medicaid programs.

Once you have identified an appropriate measure, what kind of adjustment should be provided?

1. We believe a continuous or sliding-scale adjustment, which would provide a higher adjustment for a more disproportionate hospital, is preferable to a single fixed adjustment which might be provided to all hospitals meeting a particular definition of "disproportionate share". This is the kind of adjustment approved by Ways and Means.

2. If a sliding-scale adjustment is adopted, the question remains as to the most appropriate threshold for triggering a hospital's initial entitlement, such as the national average of whatever indicator is selected, or some higher level of low-income effort. Put another way, how may hospitals be eligible for such an adjustment? (See Chart 8)

3. What should be the actual level (or amount) of the adjustment? For example, the House Ways and Means Committee would increase the federal portion of a hospital's payment by .7% for each 1% increase above the national average in a hospital's proportion of low-income patients.

4. What should be the total cost of this adjustment to the Medicare Program?

We do not have answers yet to all of these questions, but we do not believe answers will be difficult to find if we search for them together in good faith and not allow arbitrary budget targets to cloud our vision.

We would now like to comment on the interim final regulations published by the Administration on July 1, 1985 in response to a federal court order in Redbud Hospital District vs. Heckler. As you may know, the Department was turned down in its effort to get the 9th Circuit Court of Appeals to grant an emergency stay of the effect of this order, but has now appealed successfully for such a stay to U.S. Supreme Court Justice Rehnquist.

While the stay thus has the effect of halting these current administrative efforts, pending a substantive appeal of the lower Court's order, we understand some consideration may be given to enacting a requirement similar to that contained in the July 1 regulation. In summary, we believe that process to be severely deficient in several respects. No specific criteria are set forth for hospitals seeking to apply for an adjustment. No level of adjustment is proposed or methodology established for setting one. No assurance is given that any adjustment could even be "justified" -- indeed, quite the opposite impression is given, with the pronouncement that the Department continues to believe such adjustments are inappropriate. For these reasons, if a case-by-case appeals mechanism such as this one is going to be considered by this committee, a great deal of work would remain to be done.

IV. UNDERSTANDING THE "RIPPLE" EFFECT OF PROSPECTIVE PAYMENT AND PRO-COMPETITIVE ENVIRONMENT ON PUBLIC HOSPITALS -- AN OVERVIEW.

Up to this point, I have confined my remarks to technical aspects of the Medicare prospective payment system and the direct impact on hospitals like Parkland. This is just part of the picture, however, because the indirect and/or "Ripple effect" of the prospective payment system are at least as significant, if not more so, for public hospitals.

The prospective payment system has been implemented as the entire hospital industry has become increasingly competitive. In Texas, for example, for-profit hospital corporations now own or manage 50% of the hospitals in the state. Many hospitals that were founded as public or non-profit hospitals have been acquired by investor-owned chains and are now for-profit hospitals. In order to compete in price, many private non-profit hospitals have backed away from community service and charity care. As a result, people needing medical care who lack insurance or other resources -- the working poor -- are being squeezed out of the private sector and shifted to already overcrowded public hospitals.

Parkland's midnight occupancy rates, for example, have been at functional capacity because of isolation needs such as AIDS, tuberculosis, hepatitis, etc.

Since we admit so many patients during the 11 to 7 shift, our 7.00 a.m. census (a non-reported industry standard) often approaches 90- 95% forcing cancellation of needed but elective surgery or medical care. Furthermore, the patients we are seeing are sicker than in the past. For the first time in Parkland's history, we have had to repeatly implement a diversion policy for critically ill patients needing intensive care because all our adult intensive care beds stay full. This policy was activated 12 times in August of 1985. The number of babies born at Parkland has increased by approximately 12% over the previous year, while most other hospitals in the area report little change in that respect. Some 12,550 babies were born at Parkland in fiscal year 1985, making Parkland the third busiest maternity hospital in the county. The 1st and 2nd busiest hospitals are Jefferson Davis Hospital in Houston, and Los Angeles County Hospital. Both are large public teaching hospitals and members of NAPH. The collection rate for maternity patients is much worse than the rate for Parkland's other services (approximately 17%). Consequently, overall collections for the hospital have declined while the service provided has increased. In that same time period, overall Emergency and outpatient visits have also increased by 50,000 visits per year to over 450,000 visits. Again, collections for ambulatory case are minimal in Texas (approximately 10%).

Total admissions have decreased slightly on the medical and surgical services, as paying patients have had to be diverted at times because of the higher census of indigent patients. Elective surgeries were shifted to non-profit hospitals that neighbor our campus. Since they only have 60% occupancy rates, they can, and do court our faculty's private referral practices. The reasons our admissions and occupancy rates stayed up during this period, while other hospitals' declined, relate to the change in patient mix toward obstetrics and new born care (deliveries increased nearly 3,000 over the last 3 years). The lower collection rates and the increased costs from these changes are having a more profound effect on our budget than the direct changes in reimbursement under DRGs. One reason for the increase in severity-of-illness in Medicare recipients in our hospital is the lack of available beds which precludes many needed but "elective" admissions. The number of Medicare admissions at Parkland has actually decreased substantially over the last two years while the length of stay for this sub-population increased 4% to 9.73 days which is still below the national average. This is another indication that admitted Medicare patients are sicker now than two years ago. This phenomenon may be occurring in other hospitals as well but the nurses who work for home health agencies in Dallas lament the "Quicker and sicker" discharges they must deal with and the increasing acuity of care for their clients. Perhaps one reason our length of stay has gone up is because we employ case-managers for the elderly. They will not (by hospital policy) place our patients into "no care zones" to maximize our DRG reimbursements. These same case managers and physicians have helped us lower the length of stay in non-Medicare patients from 7.4 days in 1981-82 to 6.3 days in 1984-85. At Parkland, any further restriction on admission criteria, which are too stern now, or reduction in length of stay could only be accomplished at patient expense, and would clearly represent explicit rationing of health care. I am describing a situation where massive amounts of uncompensated care have been shifted to a public hospital over and above its mandated responsibilities. Sadly, this is not a unique story, just an example.

Congress and the lay public are perhaps more aware of the growing problem of "patient dumping", or transfers. At Parkland, transfers rose from 70 per month to over 200 in 1982-83 and now average almost 150 per month for fiscal year 1985. Parkland does not experience the most transfers of any hospital in the country, but we probably have a better grasp of the situation than any other hospital since we implemented our medical hotline system and transfer policy in October of 1983.

The principle objectives of that policy and system were to ensure the orderly and safe transfer of patients who legitimately should be cared for at Parkland and to discourage inappropriate transfers. The system was not intended to shut the door on transfers, and in fact, Parkland approves more than 80% of the formal requests. The policy and system have not placed an onerous burden on other hospitals and physicians, as indicated by the current compliance rate of 85% and patient stability in transfer has improved.

Largely as a result of Parkland's willingness to bring this problem to the light of public scrutiny, and in recognition of the likelihood that patient dumping was getting out of hand, the Texas Legislature enacted legislation this year to ensure the safe, orderly, and appropriate transfer of patients between hospitals.

In considering the proposed anti-dumping legislation in Congress, it is important to remember that the problem is not the appropriate transfer of patients for legitimate medical reasons. The problem is the callous disregard for human life when doctors and hospital administrators allow money to interfere with medical judgment and what is best for an individual patient. Patient dumping is only a symptom of the larger problem on uncompensated care, but it must be addressed now, before more patients suffer and perhaps die because they do not have the money to pay for their care. Undercompensation for Medicare "outliers" encourages some hospitals to transfer these patients to public hospitals. Not only is this ethically and perhaps legally wrong, the transfer of liabilities to others defeats the purpose of a prospective payment system.

Potential Answers For Rational, Instead of Rationed, Health Care

There is growing concern within the business community and among elected officials about rising health care costs. "Cost containment" threatens to overtake quality and access to care as principle goals driving health policy, and "competition" is seen more and more as the answer to runaway inflation in the health care industry.

As a physician and as a public official concerned about health policy, I am deeply troubled as I see "quality of care" and "access to care" pushed aside in this debate. Society must not lose sight of the fact that good health care policy can also be good business.

Politicians should be mindful that funding support for preventive health need not be a burden. For when monies are strategically placed, they can pay dividends by decreasing the need for higher cost acute care. Inaction on health policy issues can be even more costly than new programs and services.

Physicians have long understood that prevention of disease and injury, and early intervention in the disease process, are far more cost-effective than emergency or crisis care. Every dollar spent on prenatal care, for example, saves as much as three dollars on neonatal intensive care.

Even more cost-effective is the provision of adequate nutrition to the pregnant mother and fetus. It has been shown that every dollar spent in the WIC Program saves six to eight dollars over the lifetime of the child by the prevention of low birth weight conditions, the need for special education, the need for institutionalization, etc. Even these estimations of savings fail to account for the potential improvement in human productivity, upward mobility and an expanded tax base instead of tax burden for future generations.

Improved nutrition and social support, as well as home health care, for the elderly would be far more cost-effective than a continued emphasis on hospital and nursing home care. Improved access to primary care, especially for children, in medically underserved areas would likely reduce the need for costly hospitalizations.

How can our legislators, our policy makers, our major purchasers of health care, and our health care providers make rational decisions about the cost of health care if they have not yet determined the end-product they desire? Our nation needs a strategic plan for public health, indigent care, and health care cost containment, instead of being driven by arbitrary budget targets.

In fact, there is a glaring lack of a strategic plan for health care and health care spending nationally and at state levels. There is no definition of real need, no ideal levels of health services of health indices.

Instead of a public discussion of strategies that address both cost and quality, as well as access for the poor and medically indigent, the general public is being fed a steady diet of "cost containment" and "competition" as the answer to health care costs. Unfortunately, "cost containment" has become a disguise for retrenchment and restricting access to services for certain vulnerable populations. Similarly, spending more on indigent health care is often attacked as "inflationary". In fact, cost containment strategies that essentially restrict access to needed services will prove to be anti-inflationary only if we, as a society, completely turn our backs on the indigent and working poor in need of crisis care.

A true cost containment strategy should not result in the rationing of health care for needed services, but more appropriately it should focus on issues such as defensive medicine, tort law reform, inappropriate use of ancillary services, the real value of high cost technology and intensive care services for the terminally ill, alternatives for delivery of the same or higher quality of care at lower costs (day surgery, hospice care, home nutritional support, continuums of care for the elderly, etc.). A true cost containment strategy should also focus on duplication of services within the health care delivery system. While duplication is usually overestimated by those who espouse an interest in cost containment, it does exist. A true cost containment strategy could also explore the development of non-profit joint ventures between hospitals to acquire expensive technology such as lithotripsy or magnetic resonance imaging.

Pouring more money into a consumption-oriented system, as we have done in the past, is indeed inflationary. The indigent health care package adopted in the 1985 session of the Texas Legislature is important partly because it is addressing the root causes of many of the problems that ultimately lead to cost shifting (hidden taxation) to underwrite the care of the indigent and uninsured and, if implemented correctly, it should be truly anti-inflationary. On the other hand, if Medicaid programs are cut at the Federal level across the board without bringing conservative State Medicaid programs up to a national average, the inequities that exist now for the poor in those states will be further magnified. The significant gains made in Texas to improve the level of support for the indigent certainly will be jeopardized. Federalization of Medicaid eligibility standards would help these states, but in a "budget neutral" condition, some of the states would suffer. Perhaps we should think about poor people and equity more than about institutions or states.

If we provide the disenfranchised with access to a reasonable level of health care, competitive strategies can perhaps squeeze out many of the inefficiences that do exist in the health care industry for without America having to embrace Social Darwinism as a health care policy. The competitive environment which currently includes advertising and sophisticated marketing, may just as well lead to more consumption and higher overall health care expenditures even as the poor are displaced to an already overloaded public sector.

Leading advocates for the privatization of health care for the poor often tout the management abilities of the for-profit sector. A closer look at for-profit systems reveals that health care charges to the consumers are seldom lower and when they are, it is not necessarily better management that achieves that result. In California, the acquisition of management of public hospitals by for-profit chains did result in a decrease in per diem charges. This was primarily achieved by changing the hospital's mix of services away from obstetrics, psychiatry, emergency and outpatient care, and other loss leaders to services likely to yield better collections and higher profitability. Community service and comprehensiveness are expensive. Who will provide these services in a strictly competitive model?

Certainly, few hospitals would provide a rape crisis center, 24-hour psychiatric emergency coverage, a level I trauma center, a burn unit, a neonatal intensive care unit, or postgraduate medical education if these commodities were subject to business principles and profit motives only. The ability to underwrite these sorts of services as well as medical innovations is only possible currently through tax support and cross subsidy, an inherently unfair hidden tax.

When for-profit hospitals who espouse strict competitive models are asked how such needed services can be preserved, they usually answer that society, not the provider, should pay for it, and that we must abandon cross subsidies. In other words, society should buy "more tickets to ride the same train", which by the way improves their market potential. Will this, when carried to its logical extreme actually be anti-inflationary? I doubt it, but society does need to define what it wants and whether costly health care programs should be defined as essential community services or merely commodities. This is of obvious concern to our membership hospitals which, as you know, have been designated as "essential providers" by Congress. We also represent hospitals that do not have sufficient ability to cross subsidize charity care anyway.

Last year in the United States, most hospitals saw decreasing occupancy rates and fewer surgical procedures as competition and prospective payment had major impacts on utilization. In stark contrast, urban public hospitals are bursting at the seams with increasing numbers of critically ill indigent and uninsured patients. These hospitals face a crisis situation despite county or state tax support. While the industry in general has decreased its volume of services, it has also decreased the number of employees, the expense of doing business, and the underwriting of community service and charity care. As a consequence, many hospitals still had healthy bottom lines. In such a circumstance, why would a business try to increase the production of a non-profitable service even if it could do so in a "budget neutral" way?

Rather than spreading the cost of uncompensated care over the broadest possible base, "competition" and "cost-containment" strategies may actually be shrinking the base, making the cost of charity and bad debt unbearable for certain institutions that are either politically or ethically clinging to their historical missions. The quality of care at public and selected non-profit hospitals will likely suffer because of the strain. These hospitals will be less able to attract paying patients who help underwrite uncompensated care and, in the case of the public hospital, hold down local tax levies.

States and counties will likely resist increased taxes just as the Federal government has. Without private patient revenue in public hospitals and hospital sector participation in charity care, the cost of uncompensated care shifted to a "separate but equal" public health sector would be too much to realistically expect any group of taxpayers and non-users to authorize. As public hospitals are forced to cut back or, as they become so full they cannot accept more indigent or uninsured patients, the incentives need to be there for the non-profit sector to participate in the provision of charity care.

As the competitive model evolves, for-profit hospitals may also become a part of the safety net, that is, if society is willing to buy the necessary tickets. Those tickets, however, will not be cheap. As a taxpayer, I would prefer to see my tax dollars support well-managed public systems or indirectly assist non-profit systems that actually use "excess revenues over expenses" (profits by any other name) to stabilize the safety net and invest in community service innovations in contrast to paying dividends to disembodied shareholders.

Theoretically, hospitals with an interest in equity and community service could offer lower unit prices for health care services to the various government payers in return for expanded eligibility of currently non-covered populations. This would be accomplished by selling excess capacity (through a preferred provider or HMO-type arrangement) in much the same way airlines are willing to sell empty seats after their fixed expenses are underwritten. This new money could help stabilize the safety net while increasing access, but payment would have to be fair enough to obviate the need for cost-shifting to employers and paying patients. The hospital, the payers and the poor benefit. This seems like a more ethical and more politically palatable approach than providing discounts to powerful third party carriers or business coalitions and further limiting access for the indigent.

It is also more ethical than establishing arbitrary guidelines for hospital admissions and retrospectively denying payment for health care services provided in good faith and in accordance with acceptable medical standards for non-Medicare patients. A lot of PRO second guessing is going on. To the provider at times, this activity appears to be in the interest of budget savings, not in the interest of proper patient care.

Politicians, business coalitions, and members of the lay public cannot expect hospitals to behave both like businesses and like charities. Some recognition of the special missions of the public (and certain non-profit hospitals) is essential to fairness and justice for the patients they serve.

Health care is not simply a commodity. It is different. It is a critically necessary community service. A basic level of care should be available to everyone in a society that truly values individual human life and basic human rights. We may not be able to afford liver transplants and mechanical hearts for every patient, but routinely available services cannot be rationed without lessening the value of every member of society. The NAPH membership is committed to serve and to foster creative and constructive solutions to these problems. We will continue to be an advocate for those in society we were created to serve, but we need your help to remain viable.

Thank you for your attention. I would be happy to attempt to answer any questions you may have.

CHART 1

PPS Alone Does Not Adequately Account for:

- Severity of Illness
- Multiple Diagnoses
- Multiple Procedures
- Inner City vs. Suburbs
- Differences in Case Mix
- Extraordinary Circumstances
- Disproportionate Share of Low Income Patients

CHART 2

Disproportionate Share Hospitals Have Higher Costs (100 Largest SMSAs)

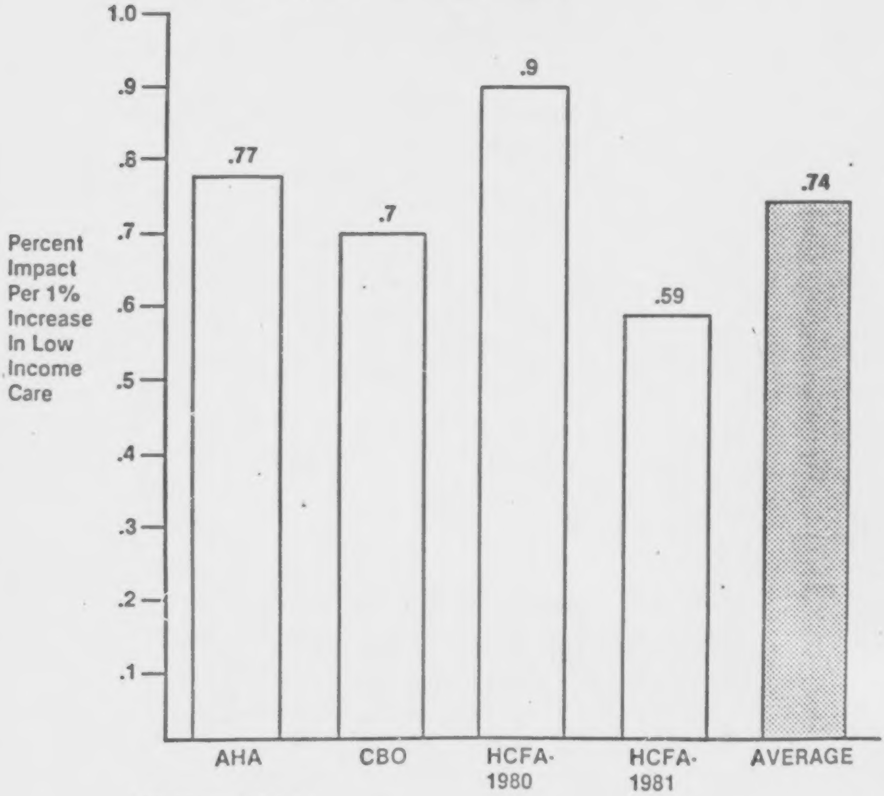
	High Volume Care to Poor	Low Volume Care to Poor
Cost Per Inpatient Day	$277.05	$235.14
Bad Debt & Charity Care as Percent of Charges	10.9%	2.9%
Net Operating Margin	−2.6%	+3.4%

"High Volume" > 13.54% }
"Low Volume" < 7.54% } Medicaid, Bad Debt and Charity Care

Source: Urban Institute

CHART 3

Impact of Serving Low Income Patients on Medicare Costs Per Case



Low Income Factors:

AHA: Medicaid, bad debt & charity as a percent of gross revenues

CBO: Medicaid, bad debt & charity as a percent of charges

HCFA: Medicaid, "self pay", and other governmental admissions.

CHART 4

What Services Account For Higher Costs In Disproportionate Share Hospitals?

- Need to Treat Sicker Patients
  - Multiple Diagnoses
  - Multiple Procedures
  - Postponed Care
  - Fewer Elective Surgeries
- Special Discharge Problems
  - Lack of Long Term Care Beds
  - Inadequate Home Setting
  - More Chronic Illness
- Extra Services Needed
  - Admission & Eligibility
  - Security
  - Translation
  - Transportation
  - Nutritional Services
  - Prevention & Education
- Higher "Standby" Costs
  - Ambulatory Care
  - Shock/Trauma
  - Specialized Tertiary Services
  - Adolescent Pregnancy
  - Poision Control
  - Substance Abuse
  - Psychiatric

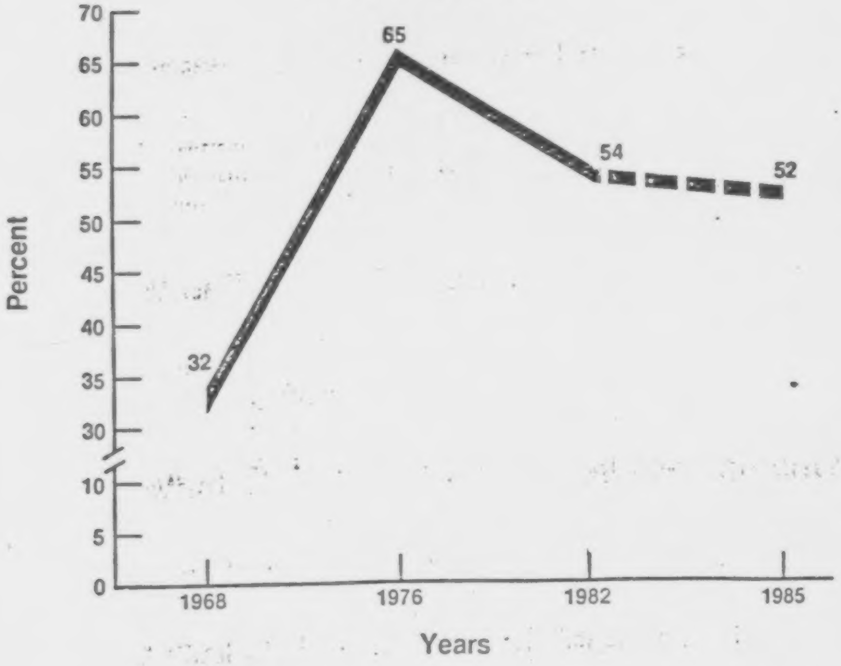
CHART 5

“Disproportionate Share” Adjustment: Implementation Issues

- Measuring “Low Income Patients”
  - Medicaid Alone
  - Medicaid, Bad Debt & Charity
  - New Cost Report?
- What Kind of Adjustment?
  - Fixed
  - Sliding Scale
- What Threshold for Hospital Entitlement?
  - How Many Hospitals?
- Level and Total Cost of Adjustment

CHART 6

Medicaid Recipients as a Percentage of the Poverty and Near Poverty Population*
1968-1985



* Less than $12,460 income for family of four, 1982

Source: Center for Health Policy Studies,
Georgetown University

CHART 7

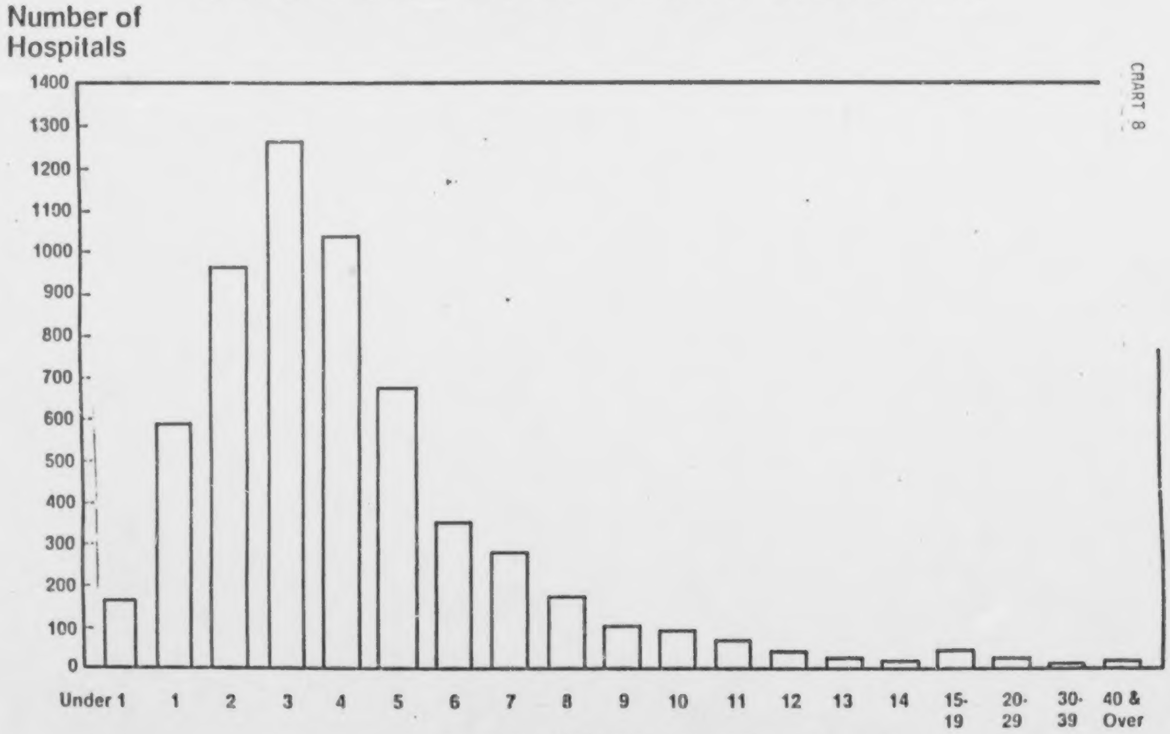
Characteristics of Hospitals Above the 90th Percentile of Care to the Poor (23% or more)

	Charity	Bad Debt	Medicaid	Total
100 Largest Cities (#'s)				
Public - Coth (44)	9.25	14.32	22.04	45.61
Public - Non-Coth (29)	13.63	15.26	18.29	47.18
Private - Coth (35)	2.49	3.45	25.39	31.33
Private - Non-Coth (82)	1.22	3.63	29.06	33.92
Rural				
Public (114)	1.28	10.77	12.49	24.53
Private (26)	1.55	3.74	23.25	28.55

Source: Urban Institute

CHART 8

Hospital Bad Debts/Charity Care as a Percent of Gross Revenue



Source: AHA

TABLE 1

SOURCES OF REVENUE AS A PERCENT OF TOTAL REVENUE
NAPH MEMBERS

Hospital	City/County & State Appropriation	Medicaid	Medicare	Private Insurance	Other*
Harris Co. Hosp. District	88.4	4.4	4.9	2.2	0
University of TX Med. Branch Galveston	70.0	3.0	11.0	13.2	2.8
Charity Hosp. of New Orleans	67.6	13.9	13.5	---	5.0
Univ. of TX Health Center - Tyler	61.1	0 2-3%	27.7	10.2	0
King/Drew Med. Center	60.7	20.8	1.8	4.1	12.4
Cook County	54.3	25.4	10.1	8.1	2.1
St. Louis County	52.2	15.4	20.9	5.9	5.5
Los Angeles Co./USC Med. Center	49.5	31.7	4.1	2.1	12.5
Denver General Hospital	47.0	10.9	16.2	10.4	15.2
San Francisco General	42.3	27.8	16.3	8.9	4.4
Harlem Hospital	39.4	31.0	20.4	3.9	5.3
Alameda County	37.2	34.0	12.8	4.7	11.3
Grady Memorial Hospital	37.1	22.4	21.0	11.1	9.9
Dallas Co. Hospital District	33.3	5.5	12.5	13.3	35.1

* May include some state or local subsidy.

Hospital	City/County & State Appropriation	Medicaid	Medicare	Private Insurance	Other
R.E. Thomason, El Paso	33.2	8.3	12.4	23.6	22.3
Truman Medical Center	31.7	24.3	20.8	13.2	9.9
Contra Costa Co.	28.4	35.8	19.7	3.1	12.7
Queens Hosp. Center	28.4	35.4	20.8	6.7	8.7
D.C. General	25.1	17.8	10.9	5.4	18.2
Chope Community Hosp. San Mateo	24.8	22.4	19.6	13.2	20.0
Bellevue	21.8	43.5	17.0	7.3	10.4
Kern Medical Center	21.5	45.5	12.8	16.9	3.1
Harbor/UCLA	21.4	45.7	11.9	7.5	7.3
Regional Med. Center Memphis	20.9	16.3	7.3	2.7	22.8
Santa Clara Valley Medical Center	19.2	37.7	20.7	21.5	.8
Bronx Municipal	19.0	40.0	23.9	8.3	8.8
San Joaquin County	19.0	44.2	17.4	7.4	11.8
Wishard Memorial Indianapolis	18.9	13.6	19.1	12.4	36.0
Milwaukee County Medical Complex	15.3	11.6	31.1	28.2	13.9
Riverside General	14.8	43.6	11.6	12.1	17.7

Mr. **Frost**. Thank you. I have several questions and then I would like to call upon other members of the task force who are here.

I want to direct your attention to section III in your statement, because when we had a hearing last week, the administrator of HCFA, Mr. Haddow, testified that they were having difficulty coming up with a definition of disproportionate share hospitals, and that was the reason that the administration had delayed implementing any type of allowance for disproportionate share hospitals.

I gather from your testimony that you feel it is possible to come up with an adequate definition. You have set out several things that should be measured. You have specifically directed yourself to the question of whether to emphasize Medicaid as the entire standard or to have some sort of combination of Medicaid and Medicare.

Is it correct to summarize your statement that you believe we can today come up with a definition of disproportionate share hospitals that would permit us to proceed with that type of an allowance for those hospitals?

Dr. **Anderson**. Mr. Chairman, I do. In Texas, actually we did put in a disproportionate share provision during the Indigent Care Task Force, and we looked at hospitals and their local tax support as a third-party payment. We looked at the charity care they rendered over and above that from the public sector. We looked at the degree of philanthropy and share of charity care for nonprofits, and in the for-profit sector, local ad valorem and income taxes to try to level the playing field. We feel we did identify charity costs per bed and were able to identify the disproportionate share. I think it can be done rather simply.

Mr. **Frost**. In your judgment, HCFA is not taking a reasonable position by saying it is impossible to come up with this adequate measurement right now and giving that as a reason for delaying the implementation of a disproportionate share allowance?

Dr. **Anderson**. I think it would be much easier to measure that than acuity or severity of illness. This is a much simpler concept that can be done. As I see from chart 8, there aren't that many hospitals that we are talking about that do disproportionate share. They stand out pretty easily.

Mr. **Frost**. I gather from your testimony that you feel that the language contained in the Ways and Means portion of the reconciliation bill adequately addresses this question?

Dr. **Anderson**. I think it is well on the way to addressing it, yes, sir.

Mr. **Frost**. Let me ask you one other question. When Rudy Penner, the Director of the Congressional Budget Office, appeared before us last week, he suggested and he emphasized that these were merely suggestions, alternatives. They were not necessarily recommendations. He was not telling us that this is the way we had to do things, but he suggested that Congress consider reducing the indirect teaching allowance for hospitals, for those hospitals that are found to qualify under the disproportionate share allowance, and that there was some degree of overlap, and that a hospital did not need to receive the full disproportionate share allowance as well as the full indirect teaching assistance allowance. Do you agree with that or disagree?

Dr. ANDERSON. I think that obviously in a budget neutral condition, if that is one of the standards that we have to meet, someone will lose if someone wins as far as disproportionate share. As I mentioned, half of the teaching hospitals do not provide disproportionate amounts of charity care or care to low-income patients.

I think that would have to be looked at. On the other hand, the indirect costs of medical education was not simply to deal with disproportionate share. It was to deal as a proxy, if you will, for many other issues like severity of illness, which has not been addressed by Health and Human Services either, so I think that we have to be very cautious about making drastic cuts, dollar for dollar cuts, but I think there is some validity to the fact that not all teaching hospitals are the same.

Mr. FROST. I guess what I am really asking, though, is if a hospital would be found to be eligible for both, both the indirect teaching allowance as well as the disproportionate share allowance, in your judgment do they need to receive the full allowances under both categories?

Dr. ANDERSON. Well, I would have to look at the individual hospitals, I think, to see if it is really true that anybody would get both, resulting in a windfall. I don't see that a lot of that will ever happen. Most of these hospitals are underreimbursed presently for a lot of uncompensated care and that will continue in either scenario I'm afraid. If we are dealing strictly with the Medicare Program, my answer would probably be no. I don't think you can separate the Medicare Program now in this Nation, from other payment systems such as Medicaid or from uncompensated care; though, we must realize that each impacts on the other. So that many of these disproportionate hospitals do need increased reimbursement if they were going to be equitably reimbursed. But strictly dealing with the Medicare Program or the "universe," I think it still would not be a dollar for dollar shift.

I don't think you could cut one dollar off of one category and shift it over to the other category without seeing these hospitals continue to suffer.

Mr. FROST. Should I assume that Parkland, once a disproportionate share formula is arrived at, Parkland would be eligible for that?

Dr. ANDERSON. It would be, I believe, if we had in the provision that the State and local government's tax support of the institution for charity care would be an acceptable condition for the definition of "disproportionate." If it is tied strictly to Medicare crossover or Medicaid in any fashion, because we have such low numbers of these patients in Texas public hospitals, we would not qualify. We have displaced these people to the private sector. We are taking care of the people who are poor and without coverage. A hospital like Baylor, in our community, has maybe 40 percent of its work as Medicare, while ours will be around 15 percent. Our Medicaid is only 7 percent. So you know it is relatively a situation where we are taking care of the people who have no coverage at all. Texas is 48th lowest in the Nation in Medicaid.

Mr. FROST. Right. Presumably the definition could be devised that would permit a hospital like Parkland to fall within that definition?

Dr. ANDERSON. Yes, sir, I think the definition that we would suggest is a 30 percent local or State tax support for the institution, as a proxy for the Medicaid mix or the Medicaid-Medicare crossover mix. We think that would be fair.

Mr. FROST. When then Secretary Heckler appeared before this committee last year, and I asked her some questions about the indirect teaching subsidy, and basically the administration's position at that point was for the elimination of the program, they subsequently changed or altered their position somewhat. But she testified at that time that there were many hospitals that really did not need it, did not deserve to have it, teaching hospitals, and that were making a good deal of money, and that they were having trouble sorting out which ones needed to receive it versus which ones didn't. And so they were considered—they had recommended at that point to eliminate that subsidy entirely. Is that a reasonable position? I gather from your testimony that it is possible to determine which hospitals really need this type of assistance.

Dr. ANDERSON. Then Secretary Heckler could have as easily said pay them all instead of not pay any of them if she really wanted to see a good-faith response, if she couldn't determine who should and shouldn't be paid, particularly since some of these hospitals represent the true safety nets in States without strong Medicaid programs. I think that they could have made a determination at that time that these were important passthrough payments and that they should continue, and that maybe hospitals, maybe a few hospitals, are examples where there are windfalls.

Any time we average out all hospitals in the country and treat them the same—and we have done that with the DRG program—then we will have windfall gains in some areas and we are going to have others who are being paid too little resulting in a deficit situation. So I don't think we have average men. We always talk about the average man and certainly we don't have many average hospitals. Nobody wants to think they are average, but I think there is a unique group of hospitals in this country that are disproportionate share providers and they cannot be compared and thrown in and averaged out. Most of these are also tertiary referral centers.

They take care of much sicker portion of the population and they provide more indigent care. They provide a lot of other nonprofitable community services that no one else will provide. If we compare those hospitals to everyone else, they will always be underreimbursed.

I think that HHS should be held accountable for defining what indirect costs should be, and the fact that we have enough doctors now shouldn't be the reason that we underreimburse these hospitals. And if we decide not to pay for indirect medical education, we certainly should pay for those things that it was a proxy for.

Mr. FROST. Mr. Weber.

Mr. WEBER. No questions.

Mr. FROST. Mr. MacKay.

Mr. MACKAY. The State of Florida in the past couple of years adopted a sick tax, which required in effect for-profit hospitals which are not providing certain of these services to levy a tax and put it into a common pool to help subsidize the cost of hospitals like yours. Have you looked at that in Texas, and what are the politics of health care for the indigent at the State level? In other words, what is happening in Texas, leaving the Federal Government out of it?

Dr. **Anderson**. In Texas we just had four pieces of legislation passed called the Indigent Health Care Package. The Maternal and Infant Health Care Improvement Act provides $22 million to deal mainly with high risk pregnancies and prenatal care. Feeling that we could save a lot of money, $3 to $8 for every dollar spent, WIC was supplemented. We also address the need for primary care in the 49 rural counties that don't have access to primary care, but this supplement is very modest.

Also, a bill was passed to stop unstable patient transfers that were occurring because of an increasingly competitive environment. We tried to pass a bill to deal with the responsibility of hospitals. We did define responsibilities of counties that did not provide indigent care up 10 percent of their gross revenue, which covers only the poorest of the poor, about 25 or 28 percent that are not covered by Medicaid or some other program.

The sick tax portion of the legislation did not pass, and frankly the public hospitals in the State weren't for the sick tax per se as much as we were for an "access to care" provision, where each hospital, if nonprofit, would have to provide at least 3 percent charity care like a Hill-Burton obligation. We wanted to improve access and quality and have everyone participate at a more equal level, define the minimum, not maximum, level of participation. The community would define the maximum level. We wanted the for-profits to do the same thing but we would take into account their taxes paid.

I didn't personally think that taxing the hospitals as one single industry, taking the money to Austin and then redistributing it, would ever be done fairly. We wanted to improve access. Our beds are full. We are bursting at the seams. We don't need the money as much as we need a way for some of the patients to be cared for in the nonprofit sector right now. Short of that, we would have to expand, and I think that would be a cost in brick and mortar that wouldn't buy any health care, so we weren't really for the sick tax, although we were accused of it by for-profit lobbyist and it didn't pass.

Mr. **MacKay**. Has the Texas Legislature significantly expanded the Medicaid coverage in previous years?

Dr. **Anderson**. We have been always at the bottom, around 48 lowest. We fought for the lowest position but South Dakota and Nebraska beat us. I think that we have picked up some programs for the deemed pregnancy women, for the so-called Ribicoff children—under age 5 in two-parent families—we expanded marginally in October 1984, and the total indigent health care package, which was $70 million, plus $20 or $30 million from the counties, and with Federal match for Medicaid, comes up to around $200 million total increase. But the amount of uncompensated care in Texas is approximately $1.3 billion in hospitals, the majority being in public and nonprofit hospitals.

Well over half of that really comes from the public sector, about seven or eight large public hospitals. So we are talking about a situation in Texas where the hospitals still, through either cross subsidy or some other mechanism, pay for the lion's share of uncompensated care somehow. All care is paid for, but usually it makes us not as competitive, if you will, as a for-profit or nonprofit who won't do charity care or provide access.

If we are going to have a truly competitive environment, and we are not afraid to compete, our special community services must be recognized as important contributions to our cost that should be reimbursed, and also we should not be strapped with everyone else's liability. That is what is happening now in Texas. We can't possibly compete. I have actually discharged paying patients to put charity patients in there because our beds were full. That is our mandate and we meet it over and above, truly in a disproportionate way.

Mr. **MacKay** And the excess uncoverd cost is essentially coming out of local property taxes?

Dr. **Anderson**. Well, the property taxes in Dallas County, for example, failed to cover our costs, not our charges for charity care last year, by $12 million. We had $12 million in costs transferred to us from out-of-county patient referrals, charity patients other counties didn't take care of their responsibility, and $13 million in cost from Dallas county hospital transfers that have as much of a mandate to care for noninsured populations as we do, but they transfer this responsibility to us.

We had a $12 million gap in local tax support fund but we could have closed it by closing access and letting the courts decide, but we didn't want to put the patients in jeopardy. We went ahead and took them. So right now the property taxes do not cover it fully. We were lucky enough to have a commissioner's court that put money in reserve for us some years ago to handle cash flow problems and the interest income has been the only way in the last 2 years that we have had a positive bottom line. Our revenues over expenses have been negative or near negative, and that is true in most of the public hospitals now.

If they have a positive line, usually it is from nonoperating, nonpatient care revenues. We did win a bank stock litigation last year. Some critics in the for-profit sector pointed out our $5 million bottom line that year not realizing that we actually won $5.2 million in the bank stock litigation, so we did have a bottom line that was positive.

Mr. **MacKay**. That is strange. I guess when you are trying to figure out funding policy, that is a strange way to end up making the gap come together.

Dr. **Anderson**. We have had tremendous support, sir, from our county over the years. In Texas, large urban counties probably have supported their public hospitals twice as well as many of the other counties around the country, because they had to. We have not had the State and the Medicaid Program to support us.

Mr. **MacKay**. Mr. Chairman, if I have got time for one more question.

One of our witnesses last week said that he could foresee a crunch in the Medicaid Program because it was picking up the cost of long-term care for the elderly, and he saw that as an increasing cost which in effect put the elderly very directly in opposition, their needs directly in opposition for the same dollars that are covering basically the welfare or indigent costs, medical costs. Do you see that coming, or do you see any evidence of that?

Dr. ANDERSON. Right now in Dallas and Houston many of the skilled IV beds have evaporated. About 50 percent of them have gone away because the nursing home industry can't make enough on the Medicaid patients who are that ill. They are backing up in the hosital, but already in Texas the seven large public teaching hospitals do more in hospital indigent care and physicians services than the entire Medicare Program in Texas. But if you look at what is spent for Medicaid in nursing homes, it is two to three times greater than acute care costs, so already in Texas the preponderance of the Medicaid Program for health care is going to nursing homes.

I do think that—one of the problems that I have, sir, in southern California, HCFA did have a Medicaid waiver where they looked at incentives to get people out of nursing homes to make them more independent, improve functional life and not necessarily just extend life without quality. They reimbursed with incentives to get people on through the system. We don't do that in Texas nor do any States I know. We pay to warehouse the elderly and not to find a continuum of care, perhaps like the ONLOK Program in San Francisco should be well studied because there are ways, HMO models, home care hospice, foster-adopt-a parent programs, and that sort of thing for the elderly that can be done well and with higher quality from the elderly patient perspective and lower cost to the entire country.

I think those are the ways we can improve access to care without rationing, and we are going to have to do that. We can't continue to emphasize institutionalization and afford it. We are not that rich a country.

Mr. MACKAY. Thank you very much. Thank you, Mr. Chairman.

Mr. FROST. Dr. Anderson, thank you very much. Parkland, of course, is an outstanding hospital in our part of the country. It does a wonderful job for our community. I appreciate your testimony here today. It has been very helpful on some matters that we will have to face next year when the budget resolution is being considered by this committee. Thank you for your appearance.

Dr. ANDERSON. Thank you, Congressman.

Mr. FROST. At this point I would like to call out of order Dr. Charles Schramm, Johns Hopkins University, Baltimore. Mr. Schramm has a scheduling conflict, so I would like to give him the opportunity to testify this morning.

STATEMENT OF CARL J. SCHRAMM, DIRECTOR, CENTER FOR HOSPITAL FINANCE AND MANAGEMENT, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Mr. SCHRAMM. Thank you, Mr. Frost. I appreciate the courtesy of the Chair as well as that of Dr. Buck, Ms. Davis, and Mr. Melton, who follow me.

In your letter of invitation, you asked me to come and talk a bit about the lessons we have learned about PPS so far, and to offer some comments on what I thought might be areas of further savings. I should say at the outset that I am director of the research center at Johns Hopkins University known as the Center for Hospital Finance and Management. This is the home of some of the work on DRG studies referred to by Dr. Anderson. My colleague Dr. Horn is in charge of our severity work. I have also served for over 8 years as a member of the Maryland Health Services Cost Review Commission, which is the granddaddy of the rate regulation agencies at the State level.

I think it is in this latter capacity that the lessons of the Medicare prospective payments system [PPS] is best put in context, because the prospective payment system, as passed by the Congress 2 years ago, essentially is based on the model and the experiments at the State level with ratesetting. It is indeed similar to our regulatory system in every respect save one, a critical one, and one that has been discussed today, namely, it does not apply to all payers. Rather, the Congress has behaved as if Medicare is indeed an insurance company, and by setting a unilateral because it is government, a regulated price schedule, savings could be extracted.

The first lesson I think is what we know about what has been accomplished on the inflation scene. It is clear that hospital cost inflation has been reduced relative to our experience of 3 and 4 years ago. There is no definitive evidence, however, that the PPS has contributed to this. You will recall that general input prices have been reduced significantly in the same period. Moreover, hospital prices are still increasing at 9 percent while the CPI is less than 5 percent. Thus, while the hospital cost inflation now looks low compared to the years in which we had 17 percent inflation, there is no relative advance in any real way.

In the States where prospective budgeting obtains for all payers, namely Maryland and its sister regulated States, we continue to observe rates of inflation in per capita expenditures of 3 and 4 percent below the national experience as recently as 1984. Indeed, the ratesetting regimes have worked so well that in one State, New York, hospitals have worked to overturn the Medicare waiver; savings affected by the State's system were so large, hospitals were forced to forgo huge amounts of Medicare revenue. State hospitals forged a political coalition to persuade the commissioner of health to withdraw from the waiver experiment.

What then are the lessons here? Not that unilateral ratesetting by the Federal Government for Medicare results in systemwide savings. Rather, you have shown that when a prospective limit is established on how much any one payer will pay per case, hospitals will move to reorder their prices, rather than to reorder their budgets.

If budgets had begun to change in dramatic ways in some hospitals, it is because the utilization pattern for the under 65 population is changing, an outcome without link to the Medicare reforms. Hospitals have continued to shift unmet revenue needs to other payers. Moreover, hospitals have used the reform in Medicare payment and the aggressive behavior of private payers to change their pattern of care and service without knowing what the impact may be on the patient population.

Every financial inducement exists to discharge patients prematurely. Inpatient care has been made markedly cheaper in many hospitals by cutting the number of nursing hours per patient. Hospitals speak openly of demarketing the poor. Evidence is building in many cities, as you have heard from Dr. Anderson, that persons formerly accepted by community hospitals are finding it difficult to receive inpatient attention.

Unfortunately, it appears that in the name of cost containment, with the encouragement of the Federal Government, many hospitals have reduced their services and their commitment to care, and have continued to keep prices unnecessarily high. Indeed, last year the voluntary hospital sector reported for the third year in a row record high margins of 7.5 percent. The for-profit record is equally clear.

Their profits have been growing continuously for nearly 20 years. Indeed, last week a small downturn in earnings in the nation's for-profit hospital sector sent the markets into a decline and had effects in the European capital markets as well, for many of them proudly draw on their leverage position for debt credit.

With that as a gimmick, you might gather that I am not the world's greatest fan of hospitals and their community obligations to save us costs. As a regulator, I form my opinion that hospitals will essentially operate to change their prices first, rather than their expenses, because it is easier for all kinds of reasons.

Thus my first recommendation to you would be forget about staying the in-patient schedule from national to local and regional rates. It should proceed on order, ~~and~~ likewise, you should not think about freezing marketbaskets. Indeed, I think good regulatory practice since the Congress and the administration are in the business of regulating hospital rates, to behave in a predictable way without letting political interruptions disrupt the system.

Now with that having been said, I do believe there are some areas where you should contemplate change because of inequities or because the mechanics are working poorly.

The first area I think regards the disproportionate care question that you have already heard about. This is a question of profound importance to a number of hospitals, although the number is not well known, because they are the target of dumping, and because for historic purposes they do deliver a disproportionate load of care to patients who cannot pay the full freight.

This problem of course is alleviated in States where there is an all-payer regime, like Maryland. There is no problem with disproportionate share because all hospitals operate in a disinterested fashion regarding all patients because the State regulatory commission spreads bad debt evenly and equitably throughout the State.

The second area I think you should consider regards mechanics. First with regard to technology and second with regard to how well the DRG's measure severity. You will be assaulted in the years to come, and certainly next year for sure, with ProPAC's recommendations regarding changes to accommodate new technology. They must be accommodated.

Regarding the DRG's, there is accumulating evidence that DRG's—while they measure for the bulk of hospitals' case mix quite adequately—do not adequately treat a number of tertiary care hospitals, and probably some high substrata of that. Thus I believe that there should be an adjustment for severity. Some kind of adjustment is doable rather cheaply, and this should be explored in advance and not precluded merely on the simple assumption that increasing the number of discrete categories is administratively cumbersome.

You will hear and have heard about another area of reform, namely, graduate medical education. Several studies required and mandated by the Congress have yet to produce their findings. I would only offer that while graduate medical education must come under your scrutiny, we must proceed very carefuly here. I believe we have not had the adequate public debt that is necessary to set the overall tone for public support here, and that operating merely on the precept of saving Medicare money may prove to be inadequate and inequitable as regards the hospitals that are fairly bearing an enormous GME burden; and, as regards one of your questions, this burden is enormously uneven.

The final area I would like to speak to is a new area for your committee, I believe. It is an area that needs and merits enormous amounts of attention in the future, and that is one of overcapacity in our system. We are no longer at the point of talking about hospital capital in terms that used to characterize debates over health care planning. Rather, the issue that confronts us now is doing too much planning, planning too well, and having overbuilt our system.

Last year the Governor's report in Maryland indicated that fully one-third, 5,000 of our 15,000 beds, are unnecessary and should be shut within the next 5 years. At the same time, only a few months earlier, the Governor's report in Ohio indicated there were 9,000 unnecessary beds in that State. There is a report in the State of New York Health Department that indicates that over 8,000 beds are operated in the city of New York unnecessarily.

The issue of overcapacity is profound. We must get rid of unnecessary capacity. Hospitals at this point are enormously uncertain about what to do. I would suggest that rather than the three things currently talked about and before the Congress, namely, reductions of the capital payment and allowance and Medicare; second, the rescinding of tax-exempt status on the Treasury II proposal of the administration; and third, in this year's tax reform package, the prohibition on financing of outstanding hospital debt to lower rates, merely indicate treatment of symptoms. What we really need is some broad sweeping reform, and I believe it would be proper in Medicare payment reform packages to get this underway, of encouraging States to get overcapacity out of the system.

There are those who will tell you that unused hospital capacity is really costless or cost free. I would suggest that Roemer's principle still holds, that as long as those beds are in existence hospitals will be ever creative in filling them; physicians' income relates to how successfully those beds are filled. Hospitals are ingenious in creating for you all kind of proposals as to how those beds are used. Perhaps the most current at the time is the conversion of these beds into long-term care beds.

The Maryland Governor's task force, of which I was a member, held hearings and was convinced by the testimony offered to us that it showed clearly that it is cheaper to build new long-term care facilities than to reconvert or convert hospitals into long-term care facilities.

I would suggest to you that Medicare has open to it a number of ways to begin this debate, and to encourage the States to get busy in deplanning, if you will, or decapitalizing the hospital industry in a number of ways.

I will conclude by saying one thing in my professor's head, and that is sooner or later a small point will arise that is not such a small point. The cost report is a matter of great discussion in hospital circles. Most administrators are looking forward to the glorious day when the PPS will render the cost report useless. I would suggest to you that we must continue with the cost report for research and policy purposes.

Without the information supplied on the cost report, which could have answered several of the questions you have raised already today, we will not know if PPS is working, how it is working, how Medicare should participate in the payment of graduate medical education, what the distribution of the burden for uncompensated care is, and all kinds of other questions related to efficiency and equity in this industry.

I beseech you to continue that cost report. It is the most critical item in our arsenal of public policy and public research.

Thank you for the opportunity to speak.

[Testimony resumes on p. 151.]

[The prepared statement of Mr. Schramm follows:]

PREPARED STATEMENT OF CARL J. SCHRAMM, PH.D.

Thank you, Mr. Chairman. I am director of the Center for Hospital Finance and Management at Johns Hopkins where I am an associate professor in the Department of Health Policy and Management. I also serve as Acting Chairman of the Maryland Health Services Cost Review Commission, the agency that regulates all 54 acute care hospitals in Maryland, and the progenitor of the method of prospective payment for hospitals. I am of counsel to the Washington firm of Hogan and Hartson.

I am here today at your request to offer evidence and my thoughts on how the Medicare prospective payment system, enacted by the Congress two years ago, has affected hospitals and other providers, as well as to comment on what might be done to increase the savings to Medicare from further action by the Congress.

Let me state what I believe the experience with prospective payment has been so far and what you might expect in the future, based on the experience of those government entities that served as the laboratory for the Medicare system, namely, the handful of states that established mandatory hospital rate setting nearly a decade ago. Make no mistake about it, the Medicare Prospective Payment System was modeled on and benefited from experience in the rate setting states. Indeed, the federal revenue limitations embodied in the Prospective Payment System resemble the regulations in, say, Maryland in every respect save one. The Congress did not enact an all-payer system of cost containment. Instead, the federal government decided in 1983 to merely limit its outlays and, as was apparent in the administration's presentation at the time, Medicare PPS embodies the federal attitude that no government role in actively resolving the overall problem of hospital cost containment is appropriate. Indeed, these hearings are being held, in part, to solicit from the witnesses their views on how to effect further savings to the Medicare budget.

My testimony speaks first to the savings connected with PPS and with state efforts at cost containment for the entire hospital system. Then, I will comment on three areas of potential savings being discussed--freezing the PPS rates, including physicians in PPS, and changing the graduate medical education payment. I will also suggest that the problem with which you are dealing in the disproportionate share of bad debts issue, should rekindle some interest in state efforts at cost containment. Finally, I want to suggest to you some thoughts about capital policy, particularly as it relates to the nation's community hospitals.

Savings Connected to Prospective Payment:

The rate of hospital cost inflation has been reduced relative to our experience of three and four years ago. There is no definitive evidence that the PPS system has contributed to this, however. Recall that general input prices have been reduced significantly in the same period. Moreover, hospital prices are still increasing at nine percent while the CPI for all items is under five. Thus, while hospital cost inflation looks low compared to the years in which 17 percent increases were observed, in relative terms the problem has not been solved in any real way.

In the states where prospective budgeting obtains for all payers, rates of increase in the average cost of a stay continue to be below the U.S. average by roughly three percent. Indeed, the rate setting regimes have worked so well that in one state, New York, hospitals have worried to overturn the federal Medicare waiver because the amount of foregone federal revenue was so great.

What is the lesson here? Not that unilateral rate setting by the federal government for Medicare results in system wide savings. Rather, you have shown that when a prospective limit is established on how much any one payer will pay per case, hospitals will move to reorder their prices to other payers before they reorder budgets. (If budgets have begun to change in dramatic ways in some hospitals it is because the utilization pattern for the under 65 population is changing, an outcome without link to Medicare's change in payment.) Hospitals have continued to shift unmet revenue needs to other payers.[1] Moreover, hospitals have used the reform of Medicare payment and the aggressiveness of private payers to change their patterns of care and service without knowing what the impact to the patient population has been. Every financial inducement exists to discharge patients prematurely. Inpatient care has been made markedly cheaper in many hospitals by cutting the number of nursing hours per patient. Hospitals speak openly of "demarketing" the poor, and evidence is building in many cities that persons formerly accepted by hospitals are finding it difficult to receive inpatient attention.

Unfortunately it appears as if, in the name of cost containment and with the encouragement of the federal government, many hospitals have reduced their services and their commitment to care, but have continued to keep prices unnecessaily high. Indeed, last year voluntary hospitals reported operating margins of 7.5 percent, the third straight year in which hospitals reported increasing record profits. The for-profit record is equally clear. Their profits have grown continuously for nearly twenty years. Indeed, a small downturn in earning projections in the nation's for-profit hospitals announced last week sent the entire stock market down and infected European investment markets as well.

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1 To the extent that cost shifting pushes true costs related to the care of Medicare beneficiaries to other payers, the Congress is implicitly taxing other patients for some portion of Medicare expenses.

Proposed Reforms of PPS:

At the moment several changes to the PPS system have been proposed. Some are intended to help hospitals bearing particularly adverse affects from the system, some to adjust the DRGs, and others to save even more Medicare program funds. A move is underway to save hospitals from the scheduled implementation of the national system of payment on the grounds that hospitals need more time to adjust before the 100 percent national rate descends on them in two years. In this regard, I believe that if you are operating a rate setting system, you should stick by the rules. The most important program goal in any regulatory system should be predictability. Since the federal government is going to be in the business of prospective payment for some time, you will find it in your interest to see plans through and to adjust for undesired outcomes in midstream not by across the board changes in the rules but by small changes based on a factual showing of particular hardship for specific institutions or classes of institutions.

One such adjustment you have considered is changing the PPS payment for hospitals with a disproportionate share of uncompensated care. This is the kind of adjustment to consider because you can conceive of a factual case showing the hardship the system might work on a particular class of hospitals. (To put this in relief, why would a delay in the implementation of the global PPS rate schedule be considered in the face of record operating margins? On the other hand, hospitals with disproportionate shares of indigent patients should be able to demonstrate lower margins.) It should be noted that in states with all payer rate setting the concern over hospitals with disproportionate shares of the indigent is largely absent. Because the state systems distribute bad debt, no set of hospitals is at particular risk for indigent care expenses. Again, the Task Force should appreciate the wisdom of earlier Congresses that encouraged state experimentation with seeking system-wide reform of payment.

Regarding the mechanics of the system, you will be assaulted with requests to change the law to alter the rate schedules (DRGs) to account for several forces not currently recognized in the DRGs. One such is technology. It is without question that even in the short period since DRGs have been in use, several significant changes in technology have emerged or are certain to appear in the immediate term. To continue with a DRG system that does not allow for such changes on the grounds that the number of discrete categories must be kept manageable does not make sense. Certainly technological advances that save lives or contribute to more efficient care should be encouraged, not discouraged, by the Medicare rate structure. Likewise, where a factual case can be made that the DRG system does not work well as regards measuring the case mix in a subset of hospitals, such as those institutions that are nearly total referral hospitals, the adjustments that account for the severity of the patients in that set of hospitals should be made in the name of equity. To do elsewise is to purposefully penalize such hospitals, to make them work with rates that are recognized as discriminating against such hospitals, and, ultimately, to induce them to change the patient load they serve at some risk to the society that their very special services may not be available.

You are currently being asked to consider at least three changes to PPS designed primarily to save Medicare money. The first is the freezing of physician rates. Second, it is proposed that Medicare freeze market basket rates used in adjusting the DRG payment.
As before, I believe that once a methodology has been decided upon by the government, it is a violation of good regulatory practice to change rules in order to save money. If the initial calculations of what was necessary to have extracted in the way of savings were in error, you must live with it. It is far better, as a principle of regulation, to initiate a much tougher initial cut than to engender the notion that the parties cannot trust or rely on the representations of government. As long as the federal government continues to violate its stated intent regarding freezes, the parties will properly attempt to evade the short term effects of regulation.

The Congress is also considering changes in the indirect payment for graduate medical education contained in the current Medicare regulations. A fundamental issue lies unsolved in your deliberations, that is, the federal government support the training of the next generation of physicians. Once this question is decided, it will be easier for you to consider the level and the vehicle. As it is, you are considering reducing the current allowances, and all that is missing is a rationale. It is certainly the sense of anyone connected with medical education that the government has a responsibility for supporting the direct and indirect costs of this education, if for no other reason than you have done it in the past. If change is to be made it should be only after an explicit determination is made that the government is backing out of this area as a policy matter. Attempts to reduce Medicare outlays is hardly the basis for such a step. I believe that you can legitimately support the true costs of care associated with Medicare beneficiaries and no more. Further, as a policy matter, you can support education in certain specialties and not other, over-populated ones, as a matter of Medicare policy. Before any further steps are taken, however, a fact base regarding such costs must exist and a public discussion of the government's role in graduate medical education outside of the context of Medicare budgeting is imperative.

Capital Formation:

Perhaps the most current area of concern for the nation's hospitals relates to how government's actions will effect the process of capital formation in hospitals. Three areas of legislative activity underly the hospitals' uncertainty. The intent of the Congress to set a new formula for paying for capital costs related to Medicare beneficiaries is of obvious concern. Second, consideration of the President's tax reforms as embodied in Treasury II causes great concern to charitable hospitals that can rely only on tax free debt instruments for their capital. Finally, the planned proscription of refinancing outstanding tax free hospital debt causes hospitals to wonder on what foundations public policy regarding their capitalization rests. Is there an operating premise that voluntary hospitals should have no access to capital markets? In the alternative, are for-profit hospitals going to be permitted to continue their high-leverage game of selling equity at values based on earnings potential and then base borrowings on the book value of the shareholders' equity?

It seems that capital formation in the industry should be subjected to fairness standards. Hospitals should be paid for their capital costs based on historic commitments, limited, of course, by some ceiling on interest rates. In the face of overbedding in many parts of the nation, exacerbated by falling admissions rates and declining lengths of stay, it is critical that limitations be placed on new capital projects. Hospitals seeking approval for projects that are merely "amenity related," a not uncommon proposal in times when hospital marketing directors can make a strong case within the hospital that with a fancier lobby the hospital will be able to attract patients from other institutions and increase occupancy, should be denied access to capital. Hospitals in real need of renovation should be able to get capital provided that the markets they serve are not overbedded. To be sure, hard decisions that may reflect more on an institution's age and current condition of its physical plant will have to be made. An institution with a thirty year old outmoded plant should not be allowed to refurbish itself if a proximate new hospital exists and the community clearly would be better off with only one institution, but, hospitals should not be foreclosed altogether from the tax-free market.

In order to accomplish this goal, it is critical that state government play the key role in supervising future capital formation within the state. This relates to decisions regarding expansion of both charitable institutions as well as for-profit companies. It is folly to permit markets to determine who has access to capital given an overriding value relating to accessibility to care. Once a hospital is in place, the relative efficiencies should determine which captures more market share, and capital costs should reflect community averages (adjusted for historic levels).

Conclusion:

The lessons of PPS to date are few. We still do not know what side effects the program is having nor the dimensions of these effects. We do know that the states that established rate regulation continue to enjoy real savings in the cost of hospital care for all payers, including (where waivers exist) Medicare. The states should be encouraged to experiment with system wide reform of hospital finance, and Medicare should be flexible in states where such initiatives, including private sector regulatory initiatives, are proposed. Specifically, where rate regulation exists and where it might be appropriately tried, the government should be liberal in granting waivers from Medicare payment policies. The only standard should be one regarding cost to the federal budget--where costs will be equal to or less than projected Medicare expenditures, the program should be approved. In addition, the states should be encouraged to devise new reimbursement plans that seek to eliminate excess hospital capacity. In this regard, hospital capital formation should be a serious concern of the Congress. Where states can effect comprehensive plans for their hospital industries that will reduce redundancy, the federal government should encourage such efforts. Moreover, tax-exempt financing should be left open to the voluntary hospitals lest they suffer a profound disadvantage in the face of competition by for-profit hospital companies. In this regard, Medicare capital policy should encourage refinancings that save Medicare money.

Finally, the federal government should support the states in stimulating hospital mergers and consolidations in an effort to remove fixed capital costs in the hospital sector. Such support might take the form of Medicare waivers that reward reorganizations resulting in demonstrable Medicare savings, exemptions from federal antitrust law for mergers and consolidations where the aggregate community hospital budget will be reduced, and the development of economic incentives, to be rendered through Medicare payment mechanisms, for hospitals and physicians who, through their iniative, create practice and institutional innovations that save the Medicare system money.

Mr. FROST. As I mentioned at the beginning, I am aware that you have a time problem, and I believe you said you have to leave at 2:15.

Mr. SCHRAMM. Yes, sir.

Mr. FROST. We will try and keep our questions as short and direct as possible. I am interested in some of your testimony. You stated that last year, voluntary hospitals reported operating margins of 7.5 percent, and the third straight year in which hospitals reported increasing record profits. Should we treat those high-profit hospitals differently from the way we treat other hospitals under the DRG system? Should there be some sort of modification, or should we expect more from them or ignore this fact and treat all hospitals the same?

Mr. SCHRAMM. Well, my inclination, sir, is to take that type of performance into account. We are trying to unscramble an omelet.

If a hospital becomes efficient, there ought to be a formula, indeed, originally envisioned in the PPS, where the hospital, at least president, if you will, should be induced to continue its efficient operations.

However, if those margins are building because the hospitals, as would be my suspicion, are getting efficient by reducing costs but not reducing prices, the key question that arises is what is a charitable community hospital.

The founders of those hospitals across the country did not establish those hospitals and give their corpus in gifts to those hospitals, nor did the little people who contributed to the building campaigns before the tax-exempt era attempt to create an unowned profit hospital.

I believe that those profits, as we treat them in Maryland, should be applied to the direct delivery of patient care.

Mr. FROST. How would we do this within the DRG system?

Mr. SCHRAMM. If we could retreat to the hospital report, we might make some portion of these profits just applied as a revenue source, a non-Medicare revenue source, and adjust the cost report accordingly, apply them directly to the hospital's revenue, and run through the step down accordingly.

Mr. FROST. Does that mean that what those hospitals receive would be a lesser amount for DRG's than comparable hospitals would receive for the same care?

Mr. SCHRAMM. Yes.

Mr. FROST. That is not currently the way the DRG system operates?

Mr. SCHRAMM. Not to my understanding. We are moving to a fixed price schedule, sir, and that operates without regard to how well the hospital is doing, which is the complaint of numbers of hospitals that are not doing well.

Mr. FROST. What about the hospitals that have been losing money under the DRG system? What should we do for those hospitals?

Mr. SCHRAMM. We have to analyze why it is that they are losing money when compared to hospitals similarly situated, within the same community, with the same mix of services and patients. If it is losing money, the operating presumption is that it is not operating very efficiently.

The Federal Government is not under an obligation to subsidize inefficient operations. However, one of the reasons the cost report is so important, we are able to perform comparative analyses that would suggest a standard of efficient operation, and in instances where there are losses that are not connected to a judged inefficiency, instances like the disproportionate care allowance or where the DRG's do not adequately capture the severity of the cases, the equitable thing for the Government is to adjust upward the amount of revenue that would flow through the DRG system, a mechanical adjustment.

Mr. **Frost**. We will have testimony later to the effect that particularly small rural hospitals have suffered under the DRG system. Are you suggesting that there ought to be some special allowance for rural hospitals as a class?

Mr. **Schramm**. I have looked into the rural hospital situation in a few States, where I have examined the question relative to contemplating a State regulatory regime. The question of rural hospitals is very difficult.

Rural hospitals have a very powerful constituency and many people expect a hospital to be in their backyard, but in many States with the interstate road system, and so forth, what we really need is an institution that provides obstetrical care, cheap diagnostic care, family practice and emergency care, a four-unit hospital, and while that is difficult for many people to think about, we have to think in those terms before we immediately suspect that the proper prescription is an adjustment upward of the Medicare payment, solely because the hospital is in a rural community.

The definition of rural is enormously different in Pennsylvania than it is in Iowa, and I would suggest that a hospital 25 minutes' drive from downtown Columbus ought not to be considered a rural hospital for an extra amount of payment under DRG's.

Mr. **Frost**. One other question. If I understand your testimony correctly, you disagree with the administration on the question of a freeze in DRG rates, even though, in other parts of your testimony, you talked about the fact that a number of hospitals are doing very well under DRG's, but if I understand you correctly, because of the question of predictability, long-term predictability, that you disagree with freezing DRG's at last year's rate, and that you feel they should receive the full marketbasket inflation adjustment?

Mr. **Schramm**. I believe that is correct, and I say that principally on a view of what you want to engender in terms of cooperation from the hospital industry if you are in the business of regulation.

If you made a mistake, you have to live with it. If you make an adjustment, it is much fairer to say that rather than a freeze at the proposed level, there will be a step down through 3 years, we have made a mistake and we are going to proceed in this fashion. It is more costly, but more equitable.

Mr. **Frost**. So, are you saying we should continue with the full marketbasket inflation rate from year to year?

Mr. **Schramm**. I believe so, until you make a new regulation that is based on some empirical standard.

Mr. **Frost**. OK, Mr. Weber.

Mr. **Weber**. Dr. Schramm, I have a few questions relative to the questions of the chairman about rural hospitals. You stated that there was no definitive evidence the PPS will result in savings particularly. I presume that statement is general for across the system?

Mr. SCHRAMM. Yes.

Mr. WEBER. Have you broken down the system to try to look whether or not savings are identifiable in specific sectors. I have had some indication that the extent of the system has saved the Government money, disproportionately out of rural hospitals, is there anything to support that in your view?

Mr. SCHRAMM. I have not broken it down and I would be hesitant to offer a comment on that. I would be inclined to believe that that might happen, but I have no empirical judgment, only the speaking out of bias.

Mr. WEBER. Where would we look for that comparison?

Mr. SCHRAMM. It is possible to do a comparative study looking at the proportion of expenditures prior to PPS, and see what the relative claim to the increase was, rural versus urban, and that is how I would proceed to answer the question.

Mr. WEBER. Tell me the four areas of care that you told the chairman should be maintained in rural areas?

Mr. SCHRAMM. If there is a claim for a minimal rural hospital, and in some States, the geographic distribution is such that a full-service hospital might operate, but the Medicare sole provider regulations contemplated such a problem a long time ago, where you would have a full service hospital that might operate at an efficient level, 30 percent occupancy, in rural West Virginia, where there are no roads or something.

The four services that would be best considered would be obstetrics, family medicine, emergency, and relatively cheap diagnostic testing, to the extent that a relatively small laboratory could exist, so people could get testing without driving to the big city or having samples sent back and forth.

Mr. WEBER. What kind of distance do you think is reasonable people should be forced to travel in order to obtain care?

Mr. SCHRAMM. It probably makes a great deal of difference from place to place. One of the things that I think you would want to factor into that equation is the travel time, condition of the roads, and the per capita wealth of the State to some extent, a key ingredient.

We may not be able to distribute those opportunities for convenient care proportionately across the country.

Mr. WEBER. What kind of a drive? And I realize you may not be able to answer this question definitively, but we have a system existing in rural areas that forces some people to drive a certain distance.

We were always worried about premature deliveries, heart attacks, things like that.

Mr. SCHRAMM. Let me say the national health planning standard is 30 minutes for an obstetrical situation. You wouldn't want to change that, nothing would change at all, under my definition of a rural hospital.

Mr. WEBER. That is about, at least in any part of the country, rural areas take——

Mr. **Schramm**. Sir, my position is, to state it straightly, people will be better served if they have to drive maybe 2 hours to a referral center, rather than have it convenient, but have a poorer quality and more expensive.

Mr. **Weber**. To obtain the basic care, you have to have a physician there; right? You can't provide emergency care, obstetric care, and no physician. Is it not possible to attract physicians to communities if they know they are only going to be one of one or two.

You can have a very small unit providing very basic care and 90 miles away, you have a larger facility to provide a more specialized care. Are you going to be able to attract one, two, or three physicians, to provide that care to a more remote community?

Mr. **Schramm**. We have the Eastern Shore in Maryland and, as a regulator, I have run smack into that. We have a hospital over there that needed two anesthesiologists, and the first one was 80 percent busy. He needed somebody there as a colleague. We run into cultural and conventional imperatives. My only hope is—a duck from the question—with the incumbent surplus of physicians, those communities may look more attractive, hopefully they will.

Mr. **Weber**. Thank you.

Mr. **Frost**. Mr. MacKay.

Mr. **MacKay**. Doctor, at the outset, you seem to be saying that the only way we are really going to make prospective payment work is to follow the experience of the States to its conclusion and introduce it as a cost containment system affecting all payors. Is that your basic belief?

Mr. **Schramm**. Yes, as a basic belief, I believe we won't have a totally effective, equitable system without an all-payor system, where everybody is regulated and protected equally, if you will.

Mr. **MacKay**. I gathered from your testimony that Maryland and other States have gotten well into that. Do you feel that the case can be made that that system is working fairly?

Mr. **Schramm**. I believe it is, sir. The six States that I referred to that have been at it a long time have really been at it since 1966.

Massachusetts, Maryland, New Jersey, Connecticut, the record is clear that the per capita costs and the per case costs have been coming in since 1976 at 2, 3, and 4 percent below the nonregulated States, amounting to enormous aggregate savings.

Washington hasn't done as well. I think that the lesson there is that while the system has grown and we have had enormous expansion in Maryland, about a third of our capacity is unnecessary, and that has been built in this period. It is equitable in terms of the treatment of all payors, and it is controllable, in that you can crank the whole system down, sheltering the poor and certain hospitals.

The challenge confronting everybody, Congress, is what will happen as demand is reduced in absolute terms to specific hospitals that are redundant. In our State, we have produced a targeted plan, identifying for each of the 54 hospitals what its future might be, including closure. But faced with that, the hospitals have lobbied like crazy. The future they don't want is death for certain hospitals, but reduced life for all hospitals.

You can't carry the fixed costs for the system and let everybody have a more stringent future rather than some blossoming and others having no future at all.

Mr. MacKay. The incentives that are negative from the standpoint of cost containment appear to be there anyway?

Mr. Schramm. They do. There has been somewhat less building in those States. Maryland happens to be the unfortunate exception of exceeding the national rate of construction, but all the other States are significantly below the national rate of addition to the bed stock, relative to population growth. So there has been some ability to contain construction in the ratesetting States, better than what would be expected at the national level.

Mr. MacKay. Your idea, or the solution to the problems, like that of the previous witness, where they are taking a disproportionate share, is simply to spread that among all hospitals through the rate mechanism?

Mr. Schramm. Yes.

Mr. Frost. Thank you, Dr. Schramm. I know that you have to be back in Baltimore. We appreciate having you testify today.

The next witness is Dr. Charles Buck, Hospital of the University of Pennsylvania in Philadelphia, and he is representing the Council of Teaching Hospitals.

STATEMENT OF DR. CHARLES BUCK, EXECUTIVE DIRECTOR, HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY NANCY SELINE, STAFF ASSOCIATE, AAMC

Dr. Buck. Thank you, Mr. Chairman. To my left is Nancy Seline, staff associate, AAMC. I am executive director of the hospital of the University of Pennsylvania, or, as we like to call it, HUP.

We are a 680-bed teaching hospital. To give you some perspective on the type of hospital we are, under the original DRG calculations, we had the 11th highest case mix of all the hospitals in the country under Medicare. About 25 percent of our patients are referred to us from outside the Philadelphia area.

Prior to becoming executive director at HUP, I was the secretary of the State Health Department in Maryland, and also had considerable experience with the regulatory scene in Maryland. The health department encompassed the health planning and medicaid programs, and the ratesetting activities.

The Council of Teaching Hospitals within AAMC is comprised of a mixed variety of hospitals. Not only do they share a disproportionate load of the teaching in this country, they have a disproportionate responsibility for some of the more complex care.

The 350 members of the Council of Teaching Hospitals comprise 6 percent of all the hospitals in the country. Sixty percent of the burn care is provided in these hospitals, 57 percent of the neonatal intensive care, 75 percent of the kidney transplants, and 37 percent of the bad debt and charity care.

I want to highlight about four areas of concern, and then I would be pleased to answer questions. Under Medicare, there are two payments with the label of medical education. I would like to discuss each of those.

The direct medical education cost payment includes the cost of residents' stipends, faculty supervision and other related costs. The Ways and Means Committee has recommended no change in the current payment method, and precluded the Secretary from freezing these payments. The Council of Teaching Hospitals supports that position.

The indirect medical education adjustment has the purpose of covering additional costs associated with the broad scope of services and the greater severity of illness for patients referred to teaching hospitals. Dr. Schramm mentioned the disproportionate referral of these patients to teaching hospitals and the inability of the DRG's, from a mathematical point of view, to account for that difference.

Only the small portion of these costs are educational costs. We are aware evidence has shown the current adjustment was inaccurately calculated. Dr. Judith Lave performed these assessments. We support accurately recalculating the adjustment which would reduce it to a little below 9 percent. We urge that the recalculation include only those variables used to calculate the DRG rate and not the additional variables HCFA has suggested using, such as bed size and urban area size.

There is a great deal of confusion over the disproportionate share adjustment, its purpose and relationship to the indirect medical education adjustment. The purpose is to recognize the legitimate cost differences experienced by hospitals treating a high proportion of low-income Medicare patients.

There are additional costs for treating low-income Medicare patients, such as the additional complications that they may have because they have waited longer to come to a hospital than those with proper means.

They have longer lengths of stay because their home environment is not as suitable for recuperation. These are the appropriate reasons for the disproportionate share adjustment.

We are not suggesting that this adjustment include payments for services rendered to indigent, non-Medicare patients. As Dr. Anderson commented, there is some covariance in the purpose of this adjustment and the indirect teaching adjustment, and therefore, it is reasonable to expect that some, but not all, of the disproportionate share adjustment may come out of the indirect teaching adjustment.

I also want to comment on the pause in the transition. Basically, I believe that there are too few variables used in establishing the DRG price. While we are working to develop new ones, we should support the Ways and Means Committee proposed pause in the transition.

Why do I say there are too few variables? Think about what we have done in the last couple of years. We have taken 12 million Medicare discharges and put them into 467 patient categories, and taken 6,000 hospitals and classified them by urban and rural location and area wage index. This is a gross oversimplification of patients' conditions and of hospital complexity.

As a former regulator myself, I am aware of why we needed to simplify. I am a proponent of the system in general, because it shifts hospitals to a prospective payment system, but when it comes to identifying and including proper adjustments, we are really flying blind.

Statistically, if you want to assess what we have done, you look at the amount of explained variation among hospital costs. Using all of the factors currently included in the prospective payment rate calculations—the DRG categories, the wage rate adjustments, urban-rural adjustment, and the resident-to-bed ratio—we can only account for two-thirds of the variation in costs among hospitals.

Until we can document that the other one-third is due to inefficiency, we have to be very cautious about proceeding with the transition to the national rates. I want to respond to a comment frequently made that the pause in transition will reduce the incentive for hospitals to perform. I think that is absolutely incorrect.

First of all, going back to something said earlier, there is one other big difference between the national Medicare DRG system and the Maryland one, the Maryland DRG rates were based almost exclusively on each hospital's costs in the base year. As a result, all of the issues about adjustments among hospitals were much less important.

Furthermore, if we talk about incentives, whether the payment rate for a DRG is $5,000 or $6,000, I have the same incentive to save $500. I think it is a misstatement to say that the impact on hospitals and the incentives for hospitals would be diluted by a pause in the transition; that is just not the case.

I would like to suggest some considerations for the future. We have only explained two-thirds of the overall cost differences among hospitals, and we ought to be cautious as we move down the path of further budget reductions.

When we can explain up to 90 percent of the variation, we can reasonably assume that the difference is due to relative inefficiency among hospitals. However, when we are still explaining only 65 or 66 percent of the variation among hospitals, and when for my hospital, for example, the difference between the national rate, including the indirect teaching adjustment and our hospital base rate is 20 percent, I am not prepared to say—in fact, I am prepared to deny that the entire difference is due to relative inefficiency.

Why has this not been a problem in the past? We have received the amount from the indirect teaching adjustment and we have just gone to payments based half on our historical hospital costs and half on the national and regional payment rates. What do we need to be looking at?

We need to look at urban referral center definitions, called for originally by Congress, but not dealt with.

At our hospital, I talked to our director of the cancer center, and the director of cardiology; we are seeing increased referrals of the more complex patients to HUP.

In cardiology, we have been using the Susan Horn Severity Index as an internal assessment measure. In 1982, 8 percent of our patients in cardiology were in levels 3 and 4 in severity. These are the levels into which the most severely ill patients are classified. This year, we are up to 20 percent level 3 and 4 patients.

We see increased referrals of the more complex, sicker, complicated patients from community hospitals to our hospital, and I am sure that is true with other teaching hospitals in Philadelphia and around the country.

We are seeing increased referrals of patients with leukemia in second, third and fourth relapses. Some people might call this dumping, but I think it is perhaps appropriate that my hospital and hospitals like it receive these patients.

We spent a lot of years with health planning trying to enforce regionalization. It didn't work. I think DRG's may accomplish regionalization in a much faster way then health planning ever could have. In my view, there are a lot of good points to regionalization, but if we are going to have regionalization, we have to allow it, stimulate it, and not hold it back.

I think there is no doubt that the most severely ill patients are not evenly distributed among hospitals. Yet, the ratesetting methodology is based on the premise that they are, and therefore the calculations are oversimplified.

Regardless of whether patients actually become regionalized for care, there is a "within DRG" severity issue. It relates back to the issues I mentioned with the cardiology and leukemia patients. We also have to be aware of the system's effect on technology development. There are disincentives to develop and implement new technology, especially when it will increase costs, along with increasing the quality of care. Perhaps the more subtle effect is on the role of institutions like ours in the area of clinical evaluation.

As you know, we do not get paid for the patient care costs of research programs. I know that we have been wanting to shy away from that issue, but let me give you two examples of the many kinds of clinical evaluations that are going on at HUP. In the area of cancer, we have a cancer research center. If we have two protocols for treatment of patients, and one costs $7,000 and another costs $9,000, as the budget tightens, that $2,000 difference will become an issue, even if the $9,000 treatment protocol appears to be more effective in treating the patient.

It is not an issue right now, but as we tighten our reimbursement over time, that will become an issue, and I don't think that is the kind of work that the public or the Congress would want us to discontinue.

Similarly, we have just installed an MRI [magnetic resonance imager] after years of working with General Electric. We have been involved from the very initial decision to explore the development of MRI's clinical applications.

We now have it installed and it is a great device; but, it is like the early development of the microscope. We have no idea yet of the horizons and the total range of effectiveness of the equipment. So what are we doing?

We are taking patients with certain kinds of brain injuries or who have had neurosurgery and are testing them on an MRI and a CT scanner.

We want to see what is the most efficacious way of following those patients. After some number of patients, we will probably determine that the MRI is very efficacious. We will stop doing the CT scans, and we will publish our findings so that other places will stop doing the CT scan. This is an effective way of making sure what we are learning and our basic research efforts are being transferred to patient care.

Clinical evaluations are activities that go on in major teaching hospitals, and they will come under additional scrutiny because they increase the cost of providing service in the teaching hospital.

Finally, Congress must consider the impact of prospective payment on quality. I don't have a good measure of that. We happened to be visited by the JCAH recently. In a sidebar conversation, I said, "Have you seen any impact yet? You are visiting two hospitals a week. Have you seen any impact of DRG's?"

He replied:

> I am beginning to see it in some hospitals, where they are cutting back on things like occupational therapy, and those services that may not be as directly related to the medical outcome, but are very important to functional status of our patients.

So, I wanted to highlight for you some of the issues with which you will be faced over the years as the pot is squeezed. I have focused on the fact that we can only predict or understand about 66 percent of our total costs now, and it would be an unwise national policy to continue to just cut, if we don't first put in place objective variables that will adjust for legitimate differences in hospital cost, so we can get to where we can explain 90 percent of the costs.

All of these issues are under review by ProPAC and HCFA.

ProPAC is doing a very good job in addressing issues conceptually and quantitatively and we are supportive of their efforts. Thank you.

[Testimony resumes on p. 190.]

[The prepared statement of Dr. Buck, with attachments, follows:]

PREPARED STATEMENT OF DR. CHARLES BUCK

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to comment on the current policy debate for Medicare's prospective payment system. The Association's Council of Teaching Hospitals (COTH) includes over 350 major teaching hospitals participating in the Medicare program. In 1982, the most recent year on which the Association has data, COTH hospitals cared for over 1,680,000 Medicare admissions. Thus, the Medicare prospective payment system has a major impact on our members.

Teaching hospitals vary greatly in their size, services offered, numbers of residents, commitment to research, and the numbers of indigent patients whom they treat. However it may be helpful to describe some characteristics more commonly attributable to teaching hospitals than non-teaching hospitals. Of the more than 6,000 hospitals in this country, 1,343 are involved to some degree in the education of residents. Approximately 150 of these are Veteran's Administration hospitals or other federally-owned hospitals that do not participate in Medicare. The residents are not evenly distributed among the 1,343 hospitals. The 125 members of the Council of Teaching Hospitals having the largest programs train just over 50% of the residents in the country. The other 1,218 train the rest of the residents.

In examining the 350 non-federal COTH member hospitals one finds that while they constitute less than 6% of all hospitals in the country, they provide a large portion of the intensive services. For example, 60% of the burn care, 57% of the neonatal intensive care, and 75% of the kidney transplants, and 37% of the bad debt and charity care.

Prospective Payment: Explaining Differences

Under prospective payments, hospitals receive up to six different types of payments for inpatient services:

- Cost Reimbursement Payments

  Direct Medical Education Costs
  Capital Costs (through 1986)
  Distinct Part Units

- Prospectively Determined Payments

  Per Discharge DRG Payments
  Outlier Payments
  Resident-to-Bed Adjustment Payments (in teaching hospitals)

For the prospectively-determined payments, it is crucial to recognize that the basic unit of payment is the individual patient. The actual payment is determined by adjusting an average price by an index of expected case costliness (i.e., the DRG weight). The average price for a hospital is based on its own hospital-specific costs, the average costs of hospitals in its region, and the average costs of hospitals nationally. During the transition period, hospitals began with a per case price based 75% on their own costs. By the fourth year, hospitals receive a price per case based 100% on the national average. The national average for a particular hospital is adjusted by an area wage index to recognize differences in the cost of employee salaries.

Transition Schedule

It must be understood that by year four only three differences across hospitals are recognized in the basic per case payments: rural-urban location, local area salaries as measured by the wage index and the type of patient as measured by the DRG categories. With the exception of cost pass-throughs for capital and direct medical education and the indirect medical education adjustment, all other differences in hospital costs are ignored by year four. The differences ignored in prospective payment include hospital bed size, range of services offered, socioeconomic mix of patients, central city or suburban location, and input price differences other than wages. Past research has shown each of these variables account for real differences in hospital costs. Ignoring these variables caused relatively minor problems when prices were based 75% on the hospital-specific price components because the hospital's historical costs reflected all of its differences from the "average" hospital. As the transition moves forward, however, the hospital-specific price component decreases and the price paid does not recognize major differences in the costs of different hospitals.

Therefore, the AAMC believes too few variables are being used in setting the price per case for hospitals. As the hospital-specific price component disappears, the present system lacks adequate adjustments that would recognize legitimate differences in the costs of different hospitals. This lack of adequate adjustments could be substantially ameliorated if the price per case retained a significant component of the hospital-specific costs. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS HALTING THE PHASE-IN AT 50% HOSPITAL-SPECIFIC AND 50% FEDERAL COMPONENTS TO ALLOW TIME FOR HOSPITALS, THEIR ASSOCIATIONS, HCFA, AND CONGRESSIONAL COMMITTEES TO ANALYZE THE IMPACT OF HAVING A PROSPECTIVE PAYMENT SYSTEM BASED ON NATIONAL AVERAGE PRICES.

Direct Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly described in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

> The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated (or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes only Medicare's share of expenses incurred by the cost center and allocated overhead.

Reducing Medicare's share of the costs of medical education in the hospital will weaken graduate medical, nursing, and allied health education programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS CONTINUING THE PASSTHROUGH FOR DIRECT MEDICAL EDUCATION COSTS UNTIL A COMPREHENSIVE ASSESSMENT OF FINANCING GRADUATE MEDICAL EDUCATION IS COMPLETED AND FULLY CONSIDERED.

The AAMC is fully aware of the Federal budget deficit and its impacts on our economy. At the same time, it should be noted that teaching hospitals have experienced major Medicare payment reductions in the past few years. Hospitals have responded by holding down costs and cutting expenses, including personnel. Nevertheless, hospitals still face the inflation present in our general economy including inflation in the cost of operating clinical training programs. Any freeze weakens the hospital's financial stability. Therefore, if Congress must alter the direct medical education passthrough,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE MEDICARE PASSTHROUGH FOR DIRECT MEDICAL EDUCATION COSTS BE INCREASED BY THE SAME PERCENTAGE USED TO INCREASE THE FEDERAL COMPONENT OF THE DRG PRICES.

United States medical and osteopathic schools are presently graduating over 16,000 physicians annually. All recent physician manpower studies show U.S. medical and osteopathic schools are training an adequate number of physicians for our nation. In addition to U.S. graduates, a large number of foreign-trained physicians are entering the United States. Many of these foreign trained physicians enter residency training programs where they are supported by patient service revenues, including Medicare payments. The AAMC believes our society has a responsibility to provide necessary clinical training for physicians from U.S. schools. The Association believes no similar obligation exist for graduates of non-accredited schools or schools from outside the United States. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS ELIMINATING MEDICARE SUPPORT FOR ALL RESIDENTS WHO ARE NOT GRADUATES OF ACCREDITED MEDICAL (OR OSTEOPATHIC) SCHOOLS LOCATED IN THE U.S. OR CANADA.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for FMGs would cause substantial access and service problems for Medicare beneficiaries. The AAMC does not wish to decrease patient access to service. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS PROVIDING A THREE YEAR PHASE-OUT FOR MEDICARE SUPPORT OF RESIDENTS GRADUATING FROM FOREIGN MEDICAL SCHOOLS.

A three year transition should allow the hospital and its medical staff to modify programs, personnel, and services while maintaining patient access to care. The Association recognizes that our nation may wish to continue training a limited number of foreign graduates for purposes of economic development, foreign relations, cultural exchange, and foreign aid. The AAMC supports public funding for foreign physicians in programs designed to train and return them to their own society; however, the AAMC believes special purpose funds should be used for these training purposes.

Education for the contemporary practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Medicine involves a number of different specialties, and each specialty area has developed its own residency training period. The AAMC believes each of those training programs is essential and in the national interest; however, in the present fiscal situation, the AAMC understands program policies and fiscal policies must be balanced. The AAMC believes that any limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. Because the initial skills and techniques needed by different specialties require different lengths of training,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES BELIEVES SUPPORT THROUGH AT LEAST INITIAL BOARD ELIGIBILITY (TO A FIVE YEAR MAXIMUM) IS AN ESSENTIAL MINIMUM TRAINING PERIOD THAT EVERY PATIENT SERVICE PAYER SHOULD HELP FINANCE.

It should be understood that this approach might not provide full support for the subspecialty fields of internal medicine, some surgical subspecialties, and few other subspecialties. The AAMC does not want to leave the impression that these programs are either unnecessary or conducted without training costs. Therefore, the AAMC requests that any legislation limiting Medicare's financing role to initial board eligibility include in its accompanying Committee report a clear statement that it is an appropriate function for other Federal agencies and programs -- such as the Public Health Service, the Veterans Administration, and the Department of Defense, as well as other public and private sources -- to support subspecialty training beyond primary board eligibility.

The Indirect Medical Education Adjustment

Under the Prospective Payment System, another payment carries also a medical education label. It is the "indirect medical education adjustment." There has been considerable confusion about the purpose and calculation of this adjustment. In proposing the Prospective Payment System, the Department of Health and Human Services suggested an adjustment in the DRG payment rates based on the ratio of residents-to-beds, stating:

> The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not know precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.
>
> It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.
>
> The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment. (Hospital Prospective Payment for Medicare: A Report to Congress, December, 1982, pp. 48-49)

In helping ensure equity between teaching and non-teaching hospitals, Congress clearly recognized the multiple deficiencies the adjustment would help correct. In its report on this prospective payment legislation the Senate Finance Committee stated:

> This adjustment is provided in the light of doubts ... about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education cost is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

In the AAMC's judgment, the resident-to-bed ajdustment is a correction for weaknesses in payment system design, including:

- inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals,
- no recognition for the teaching hospital's cost of maintaining both a broader scope of services and the capacity to provide specialized regional services.
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas,
- decreased productivity which results from including trainees in the hospital processes, and
- additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is mislabeled. In fact, it is a proxy measure that could be made operational to provide adequate compensation primarily for the added patient service costs borne by teaching hospitals. The history and calculation of this adjustment are more fully described in the attached document written by Judith Lave, Ph.D., former director of research at HCFA.

When prospective payment was being considered, the Congressional Budget Office compared the system's impact on teaching and non-teaching hospitals. 71% of teaching hospitals would lose money compared with TEFRA, while only 32% of non-teaching hospitals would lose money. It should be noted that this impact assessment assumed the original or single resident-to-bed adjustment. Four factors contributed heavily to this adverse impact:

- First, the DRGs have only 468 categories for recognizing differences between patients. If each hospital received an equal variety of patients in each DRG, 468 categories would not cause serious problems. Teaching hospitals do not receive a random mix of patients. Teaching hospitals receive the sickest, most difficult and most costly cases. Without such an adjustment, teaching hospitals are hurt by an average pricing system. Unfortunately, no easily implemented system to adjust the DRG for the difference in severity was available in 1983 and none is yet available.

- Secondly, when HCFA set the regional and national average prices, they computed the average on a hospital-weighted, rather than a case weighted, basis. Therefore, in computing the average, a major teaching hospital admitting 10,000 Medicare cases had the same impact as a small suburban hospital with 750 Medicare admissions. The effect of the use of a hospital-weighted average is that the "price norm" (i.e., average price) for urban hospitals is a 255 bed hospital. In the Council of Teaching Hospitals, the average hospital has 562 beds. The scope of services and therefore average costs of a hospital generally vary with bed size. This was recognized in the TEFRA limits where hospitals were compared using bed size groups. HCFA's use of an approach that sets prices approximating the costs of a 255 bed hospital hurt teaching hospitals.

- Third, hospitals in large metropolitan areas have higher average costs than those in smaller cities, and central city hospitals have higher average costs than suburban hospitals. These costs include differences such as increased security and social services departments. Teaching hospitals are heavily concentrated in the central cities of major metropolitan areas. Because the prospective payment system does not adjust for the higher costs of central cities, teaching hospitals are hurt by the average pricing system of prospective payment.

- Finally, when HCFA estimated the factor for the resident-to-bed adjustment, they included two variables in the analysis -- hospital bed size and urban area size -- which were not included in the payment system. As a result, the computed adjustment was understated and teaching hospitals were adversely impacted until Congress doubled the computed adjustment.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for cost accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Thus, it helps correct for the fact that too few variables are used to set prices in the current system. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception.

The resident-to-bed adjustment is a crucial equity factor in prospective payment. It should be retained, but it should be properly estimated. An unbiased and more defensible adjustment can be obtained if the adjustment is re-estimated with an equation based only on the factors used in determining DRG prices. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING HOSPITAL DRG PAYMENTS.

In developing the resident-to-bed adjustment, HCFA used residents assigned to the hospital's inpatient and outpatient services. Having established the size of the adjustment using residents in both inpatient and outpatient settings, it would be inappropriate to distribute the adjustment to hospitals using only residents in inpatient settings. The inappropriateness of using only inpatient residents to distribute an adjustment calculated using both inpatient and outpatient residents was recognized by HCFA in the regulations for the first prospective payment year on page 39778 of the September 1, 1983 Federal Register.

> However, due to the way in which the adjustment factor was originally computed, interns and residents working in outpatient areas and emergency rooms should be included in the calculation of the ratio. In the original computation of the adjustment factor, interns and residents working in these areas were included in the analysis, even though the costs were excluded. Further, these areas would not affect the bed count assigned to the facility. Therefore, if we were to exclude these interns and residents in applying the factor, the amount of the adjustment would be incorrect because we would be altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factor and subsequently standardizing hospital costs based on that factor.

In the September 3, 1985 regulations for prospective payment, HCFA violated this policy by changing the rules for the distribution of the resident-to-bed adjustment to exclude residents caring for outpatients from the count. The AAMC believes HCFA's original position is correct -- as long as residents of all types are included in computing the adjustment, they should all be included in paying out the adjustment. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS REQUIRING THE SECRETARY TO CONTINUE INCLUDING RESIDENTS ASSIGNED TO OUTPATIENT SETTINGS IN THE ADJUSTMENT UNTIL THE PERCENTAGE ADJUSTMENT ITSELF IS DETERMINED USING ONLY RESIDENTS ASSIGNED TO INPATIENT SETTINGS.

Similarly, if some residents originally included in computing the resident-to-bed computation are excluded from a revised direct cost passthrough, the excluded residents should continue to be included in the resident-to-bed adjustment. Therefore,

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS REQUIRING THE SECRETARY TO CONTINUE INCLUDING RESIDENTS FROM ALL TRAINING PROGRAMS IN THE ADJUSTMENT EVEN

IF THE RESIDENTS ARE NOT INCLUDED IN THE MEDICAL EDUCATION PASSTHROUGH.

DRG Payment Rates

The prospective payment system was enacted to encourage hospitals to reduce costs. Every available piece of evidence indicates hospitals are responding by reducing their costs. Moreover, and contrary to those who felt the system would be manipulated, hospitals have also experienced a drop in admissions. Clearly, hospitals have responded to the national mandate. Therefore, in an economy that is still experiencing significant inflation and with a Medicare population that includes growing numbers of the very old and the frail elderly, the AAMC believes it is inappropriate to impose a price freeze and ignore the increased costs hospitals must incur for the personnel, goods, and services they buy. Therefore,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS INCREASING THE HOSPITAL-SPECIFIC AND FEDERAL COMPONENTS OF DRG PRICES AS RECOMMENDED BY THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Disproportionate Share Providers

Hospitals serving a disproportionate share of the poor face significant problems. Within a DRG, low income patients tend to use more services than non-indigent patients. This often results from waiting longer to seek medical care, or because of chronic illnesses and complicating conditions, or from the absence of a suitable home environment to which the patient can be discharged. Hospitals serving these patients also provide more support services ranging from medical social workers to interpreters. Thus, low income Medicare patients tend to be more costly than non-indigent Medicare patients. These costs should be recognized in the prospective payment system.

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE HIGHER COSTS OF INDIGENT MEDICARE PATIENTS IS AN APPROPRIATE EXPENSE FOR THE MEDICARE TRUST FUND.

Some analysts have hypothesized that the resident-to-bed calculation may provide some adjustment for the greater expense of low income Medicare patients in teaching hospitals; however, medical education activity is not always a good estimator of the cost burden of indigent patients. Some teaching hospitals care for a disproportional number of indigent patients; others do not. In this circumstance, a separate adjustment should be established to acknowledge the cost impact of the more severely ill Medicare low income patients using a regression model similar to that used for the resident-to-bed adjustment.

I must caution this Subcommittee that the data for an analysis of the cost impact of low income Medicare patients presents several problems. Several proxy variables are being proposed. Medicaid coverage varies across the states and Southern states are disadvantaged if the proportion of Medicaid patients is used in the analysis. Hospital charges or deductions for bad debt and charity care are also hard to interpret because they incorporate the hospital's mark-up ratio. In spite of these difficulties, it is important to assist hospitals who care for poor Medicare patients lest these hospitals and their communities become the victims of a price competitive strategy to contain hospital costs.

Conclusion

If the Medicare prospective payment system is to provide hospitals and physicians with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the costs should be recognized. The AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment system.

Attachment.

THE MEDICARE ADJUSTMENT FOR THE INDIRECT COSTS OF MEDICAL EDUCATION: HISTORICAL DEVELOPMENT AND CURRENT STATUS

Judith R. Lave, Ph.D.
University of Pittsburgh
January, 1985

This report was prepared under a contract with the Association of American Medical Colleges. I would like to thank James Bentley, Richard Knapp, Julian Pettengill and Lester Lave for comments and criticisms on earlier drafts. I alone am responsible for the interpretation and conclusions.

PREFACE

An integral part of the recently enacted Medicare Prospective Payment System is the "indirect medical education adjustment," yet there is a great deal of misunderstanding concerning the purpose of this adjustment. Its title has led many to believe that this adjustment to the DRG prices is to compensate for education and related program costs. However, its congressional sponsors and the AAMC have recognized from the beginning that these payments are in fact necessary to recognize the costs of tertiary care and the unique services which are most commonly provided in teaching hospitals, and the limitations of the Diagnosis Related Groups as a unit of payment.

In order to clarify the intent of this "indirect medical education adjustment," the AAMC contracted with Judith Lave, Ph.D., Professor of Health Economics at the University of Pittsburgh and former director of the Office of Research within the Health Care Financing Administration, to write her perceptions of the history and purposes of the indirect medical education adjustment.

I believe Dr. Lave has done an excellent job and provided a document which gives a thorough and thoughtful account of the development and intentions of this adjustment. I believe the document is worth your attention.

John A. D. Cooper, M.D.

EXECUTIVE SUMMARY

The concept of the indirect costs of medical education was introduced into the hospital payment lexicon in 1980 by the Health Care Financing Administration (HCFA). HCFA stated that in calculating the then "Section 223" cost limits, per diem allowable costs could be adjusted for a number of factors including the number of residents per bed. The "medical education" adjustment was included to account for the increase in per diem costs found to be associated with the number of residents per bed.

Since then, Medicare's reimbursement policy has been fundamentally changed. Retrospective cost based reimbursement is being supplanted by a prospective payment system. Under the fully implemented Medicare Prospective Payment System (PPS), Medicare's share of capital and direct graduate medical education costs still will be paid on the basis of reimbursable costs while prospectively set DRG payments will cover Medicare's share of hospital operating costs. In addition to the standard DRG payments and the cost reimbursed passthroughs, teaching hospitals will receive incremental payments tied to the number of residents per bed. These payments, which have become known as payments to cover the indirect costs of medical education, will account for approximately 5.5 percent of total Medicare payments under the fully implemented PPS system.

In the following overview, the concept of indirect medical education adjustment is discussed first. Next the approach used by HCFA to estimate this adjustment is outlined. Third the factors leading up to the doubling of the HCFA estimated adjustment and the implications of the doubling are discussed.

The size of payments made under the rubric "payments to cover the cost of medical education" makes the adjustment an easy target for budget cuts. However, if these payments are to be cut it is necessary that accompanying changes be made in PPS. Therefore, the paper concludes by describing changes which would enhance the equity and efficiency of PPS not only for teaching hospitals, but all hospitals and patients, including:

- recategorization of some of the more heterogeneous DRGs,
- improvements in the setting of the DRG relative prices,
- determination of improved wage indices,
- reassessment of the definition of the market for which factor price differences will be taken into consideration, and
- reconsideration of the number of locational factors that will be used in adjusting the standardized DRG rates for different hospitals.

Some of the changes, such as the DRG classification system, HCFA already has under examination. Others, such as a reconsideration of the market areas, have been virtually ignored. All, however, are of vital importance if the PPS is to provide the equity across hospitals that is required for a long term payment reform.

Introduction

On April 1, 1980, a proposed rule (NPRM) in the Federal Register introduced a new concept into the hospital payment lexicon: the adjustment for the indirect costs of medical education. In setting the proposed schedule of limits for hospital inpatient general routine operating costs for cost reporting periods beginning on or after July 1, 1980, the Health Care Financing Administration (HCFA) stated that Medicare allowable costs could be adjusted for differences among hospitals in location (urban/rural), area wage rates, bed size, and the number of interns and residents per bed. The adjustment for the number of interns and residents per bed was included to account for the increased per diem costs "due to approved medical education programs".[1]

Since then, Medicare hospital reimbursement policy has been fundamentally changed: retrospective, cost based reimbursement is being replaced by a prospective payment system. The new system includes explicit additional payments to teaching hospitals. These payments, which are also directly related to the number of interns and residents per bed, are described in the implementing regulations as compensation for the "indirect costs" of education. These payments will account for approximately 5.5 percent of total Medicare payments for hospitals under the fully implemented prospective payment system.[2]

Now under the pressure of large and persistent federal budget deficits, the social policy of subsidizing graduate medical education through increased payments for patient care is increasingly open to question. In addition, given the "budget neutrality" of the new system more payments to hospitals with large graduate medical education programs means lower payments for those hospitals with none. Some have argued that the additional payments to teaching hospitals are unfair as they reward uneconomic behavior in those hospitals. The teaching hospitals, however, stress that their higher costs are related to legitimate differences in other factors associated with teaching programs, such as the severity of illness, that make their patients more expensive to treat. Thus, they maintain these extra payments should not be described as subsidies for teaching but as legitimate payments in recognition of other factors not adequately accounted for in the new system.

Given the magnitude of the payments resulting from the resident to bed adjustment, it is important to understand its origin and evolution. This paper begins with a brief discussion of the background events leading up to the introduction of the resident to bed adjustment in 1980. Next, it describes how the adjustment was incorporated into the new Medicare hospital prospective payment system. It then goes on to examine the factors that contribute to the observed relationship between the number of residents per bed and Medicare operating costs per case. This section sets the basis for a consideration of the factors that must be explicitly considered as the prospective payment system evolves.

Background to the April 1, 1980 NPRM

Section 223 of the Social Security Amendments of 1972 authorized the Secretary of Health, Education and Welfare to set prospective limits on the amount of costs authorized for reimbursement to institutional providers under Part A of Medicare. These limits were to be based on the estimated costs necessary to provide needed services efficiently. Such estimates, however, are extraordinarily difficult to make. Given the limitations of data and methods at that time, early efforts to implement this provision focused on setting limits on hospital routine per diem costs. Routine per diem costs sufficiently above the costs of comparable hospitals were considered unreasonable and therefore not reimbursable.

Between 1974, when the regulations implementing the legislation were first published, and 1980 the methods used to establish the limits were changed in a number of ways. These changes stemmed from three interacting conditions: (1) improvements in the Federal government's ability to classify hospitals and thus to compare hospital costs, (2) a steady lowering of limits due to the improvement in classification systems and increasing pressure for Federal budget savings, and (3) revision of the methods to compare costs to respond to the needs of groups of institutions which were disproportionately affected by the lowering of the limits.

For the purpose of this paper, one such change should be noted. In 1979 it was decided that in calculating its routine per diem costs, a hospital could exclude all direct teaching costs. The direct costs for teaching were excluded because it did not seem fair to compare the routine per diem costs of nonteaching hospitals to those of teaching hospitals if the direct costs of teaching were included. The costs of teaching hospitals would surely be higher. This exclusion set a precedent for separating out direct teaching costs, a separation that carried over into the design of the Medicare Prospective Payment System.

By 1979, the cost limits were set at the 80th percentile of the costs of comparable hospitals; and the hospital size, location (urban/rural) and area wage rates were taken into consideration in determining comparability among hospitals. The Administration intended to lower the Section 223 limits further. However, any significant reduction in the limits would have hurt many hospitals; and, without any change in the grouping methodology, it would have had a particularly severe impact on teaching hospitals, especially those with very large graduate medical education programs. Thus political pressure was put on the Department of Health and Human Services (the successor of the Department of Health, Education and

Welfare) to take the special circumstances of the teaching hospitals into account.

Two options were considered to adjust for the higher costs of teaching hospitals. The first option was to create special groups of teaching hospitals. Grouping variables considered included: nature of affiliation with a medical school, the number of approved residency programs and the number of interns and residents (hereafter residents) per bed. However, data analysis did not reveal any obvious groups; for example, there were no clear cut breaks in the distribution of the number of residents per bed. Thus any effort to form groups would have created a significant boundary problem. The second option was to use a continuous adjustment procedure. Statistical analysis suggested that, after controlling for bed size, location and area wages, routine costs per day in teaching hospitals increased on average 4.7 percent with every .1 resident per bed. This empirical relationship could be used to adjust a hospital's limit.

The Office of Research in HCFA recommended application of this teaching adjustment factor (to the limit that otherwise would have been set on the basis of bed size, wage level and location) in determining the routine cost limits for teaching hospitals. At the same time it acknowledged that, despite this observed relationship, the specific cost elements increased by the level of teaching activity were not identified.[3] The recommendation to use a resident to bed adjustment was accepted, but not without discussion. There was some concern expressed within HCFA that the higher costs of teaching hospitals were due to lower levels of productivity and that pressure should be placed on these institutions to become more efficient. In addition, there was some concern that this adjustment might lead to an expansion in the number of residency programs.

The April 1980 NPRM and the June 1980 final rule made a number of changes in prior regulations: they lowered the limit from the 80th percentile of the cost distribution of comparable hospitals to 112 percent of the mean and they provided for an adjustment in the limit depending on the number of residents per bed. An explanation of the adjustment for the allowed higher costs for teaching hospitals was given in the April NPRM.[4]

> *We believe these increases in per diem costs occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. For example, a hospital with an approved medical education program may be required, for training purposes, to maintain more detailed and complete medical records than a nonteaching hospital. However, medical records are not considered educational expenses and, therefore, are not excluded from the costs subject to the limitation under the current schedule.*

Thus, this adjustment was clearly labelled an adjustment for the *indirect* costs associated with medical education programs.

The Adjustment for Medical Education Under Prospective Payment

Between 1980, when the resident to bed adjustment to the limits was adopted, and 1983 when the prospective payment legislation (PL-98-21) was passed, the approach taken to adjust for the higher costs of teaching hospitals remained unchanged. While the 223 routine cost limits were in effect, the 4.7 percent adjustment for the indirect costs of medical education continued. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made fundamental changes in the way that hospitals were reimbursed under Medicare—it extended the 223 limits to cover total operating costs per discharge and it set a limit on the allowable rate of increase in operating costs per case. Nevertheless, the method used to set the total operating cost limits for teaching hospitals paralleled that for the routine cost limits—the limit was adjusted upwards with the number of residents per bed and the magnitude of the percentage adjustment was determined by a statistical analysis similar to one used to set the adjustment to the routine limits.

The TEFRA legislation directed the Secretary of Health and Human Services to report back to the Congress by December 1982 on a method to set prospective payments for hospitals under Medicare. In designing the new system, the Secretary made an early policy decision that Medicare would pay a single price for a given product. The issues of the teaching hospitals and methods to pay for graduate medical education were reopened and alternatives to the current adjustment procedures were explored.[5] The decisions reached were laid out in the Report to the Congress.

The first major decision had to do with paying for the direct costs of teaching.[6]

> *The Department believes that the* direct *costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.*

The second major decision had to do with the indirect costs of teaching:[7]

> *The* indirect *costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more*

> *tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.*
>
> *It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.*
>
> *The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.*

The Secretary's proposal established a fee schedule for hospital services. The Diagnosis Related Groups, the DRGs, were the recommended unit of payment and the prices set for the DRGs were based on an estimate of the average cost of each DRG. The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries. DRG prices would vary with hospital wages in the area, hospital location (urban/rural) and the extent of teaching. (Although the actual payment for the indirect teaching adjustment is to be made as a lump sum, it is useful for discussion purposes to think of it as an adjustment to the rate). The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries.

The Secretary originally proposed that after adjusting for hospital wages and location, the DRG payment should increase by 5.79 percent for each .1 increase in the number of residents per bed. As before, this adjustment factor had been estimated statistically. However, in this case, there was a difference between the factors that were controlled for in estimating the adjustment factor and those factors the Secretary recommended be taken into consideration in setting the rate. This point, which is very important, is further developed below.

In determining the statistical relationship between hospital operating costs per discharge and residents per bed, analysts controlled for hospital case mix, area wages, bed size, and the size of the geographic area in which the hospital was located.[8] The statistical results indicated that controlling for the other factors included in the analysis, the Medicare operating cost per case increased approximately 5.79 percent with every .1 increase in the number of residents per bed. The analysis also indicated that Medicare costs increased with hospital bed size and that the costs of hospitals located in Metropolitan Statistical Areas (MSAs) with over a million population were much higher than those in rural or in smaller urban areas. Thus, the Secretary's decision to vary the price paid for each DRG only with the hospital's case mix, residents per bed, area wage level and location (based on a simple urban/rural split) meant that *large* hospitals located in *large urban* areas would be relatively adversely affected by the payment system. These characteristics, however, are exactly the characteristics of hospitals with large graduate medical education programs. Of the 329 non-federal hospitals that are Council of Teaching Hospitals (COTH) member hospitals, 74 percent have more than 399 beds (compared to 7 percent of the 5,655 nonmember hospitals), and 61 percent are in urban areas with populations of 1,000,000 or more (compared to 23 percent of nonmember hospitals).

The extent to which certain types of hospitals would be adversely affected by the proposed system, was vividly indicated in an impact analysis prepared by the Congressional Budget Office (CBO). CBO presented preliminary information on the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. These estimates are presented in Table I. Here it is shown that 70 percent of the hospitals with over 300 beds, 57 percent of urban hospitals and 71 percent of teaching hospitals would be adversely affected.

The negative effect of the proposed system on the nation's teaching hospitals was larger than was desirable or politically tolerable. In response to this problem, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services suggested that the adjustment for medical education be doubled from 5.79 (the original proposal) to 11.59 percent for each .1 increase in the resident to bed ratio. This was an expedient proposal which, as will be argued below, temporarily "solved" the problem of the teaching hospitals without addressing a major source of the problem; that is, that the Secretary's proposal did not adjust adequately for the differences in the market areas in which those hospitals were located.

Before passing the prospective payment legislation, the Congress accepted the suggestion of the Assistant Secretary and made several other changes to the Secretary's proposed plan. The most important of these was the introduction of a phase-in period during which the DRG prices paid to a given hospital would move from being based almost entirely on its own historical operating costs to being based on the average costs in urban or rural areas; that is, to move from a hospital specific rate to a national urban or rural rate. Under the fully implemented system, these

Table 1
Estimated Average Penalties and Bonuses Under the Administration's Proposed DRG-Based Payment System By Type of Hospital[a]

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[b]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[c]	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements[d]
All Hospitals	100	0[e]	61	+23	39	−12
Bed Size						
Less than 100	49	+23	80	+35	20	−10
100-299	34	+2	50	+21	50	−11
300+	17	−6	30	+17	70	−13
SMSA						
SMSA	52	−4	43	+20	57	−13
Non-SMSA	48	+19	81	+29	19	−6
Region						
Northeast	15	−4	45	+19	55	−12
North Central	28	−4	60	+21	40	−13
South	37	+8	72	+26	28	−9
West	20	−2	57	+23	43	−13
Teaching Status						
Teaching	18	−7	29	+18	71	−13
Nonteaching	82	+7	69	+24	32	−10
Ownership						
Nonprofit	57	−2	55	+20	45	−12
Government	31	+9	78	+29	22	−12
Proprietary	12	−1	48	+22	52	−13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.
b. Average calculated for all hospitals.
c. Average calculated for hospitals that would gain.
d. Average calculated for hospitals that would lose.
e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives February 14, 1983 rates would vary only with those factors recommended by the Secretary, the resident to bed ratio and area wage rates. However, both the House and the Senate in their committee reports commented on the increased resident to bed adjustment. The Senate stated:[9]

> *This adjustment is provided in the light of doubts. . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.*

The regulations implementing this legislation made the following statement with respect to the resident to bed adjustment:[10]

> *Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education.*

This cryptic comment could imply that the Department views the additional payment as primarily an additional outlay to cover the indirect costs of medical education and not to compensate for the weaknesses in the DRG system.

At this point, however, it is useful to leave the legislative and regulatory environment and to consider the adjustment, and what it represents, in more detail.

The Indirect Teaching Factor: What Does it Really Measure?

Nationally, the observed operating costs of hospitals with large graduate medical education programs are considerably higher than those without such programs. The important question is why are their costs higher? Are the costs of teaching hospitals higher because these hospitals treat sicker and more complicated patients who are more costly to treat? Are the costs of these hospitals higher because they tend to be located in the central cities of large metropolitan areas where it is more expensive to provide hospital services, or are their operating costs higher because it is more costly to treat patients in these hospitals? In this section these issues are addressed.

A preliminary answer to these questions is given by reexamining the results of the statistical analysis done by HCFA.[11] HCFA analysts studied the factors associated with Medicare costs per case. They ascertained that costs rose proportionately with the Medicare Case Mix Index (a measure of the costliness of a hospital's case mix as measured by DRGs) and the average wages paid to hospital employees in the SMSA in which the hospital was located. They also determined (other things being equal) that relative to hospitals located in rural areas, hospital costs in urban areas with less than 250,000 people were only slightly more costly, that hospitals located in areas with between 250,000 to a million people were 2.6 percent more costly and those located in areas with over a million population were 10.9 percent more costly. They determined that costs increased, but less than proportionately, with hospital bed size. Since major teaching hospitals have higher measured case mix indices, are located in SMSA's with high wage rates, are located in the largest metropolitan areas and are bigger, these factors will account for much of the higher observed Medicare operating costs per case in these hospitals.

Nevertheless, controlling for these factors, Medicare operating costs per case increased approximately 5.79 percent for each .1 increase in the number of residents per bed and it is this relationship that has been labelled the indirect cost of teaching.

Before continuing, it is necessary to stress that the estimate of the "indirect costs of teaching" is obtained statistically. The estimated relationship between Medicare operating costs and residents per bed will depend on what other factors are controlled for and how well they are measured. It is likely that some of the effect on costs attributed by the statistical analysis to residents is due to other variables which are not included in the analysis.[12] One indicator of the sensitivity of the estimated size of the indirect teaching adjustments to the nature of the control variables can be given here. If the analysis of Medicare operating cost per case is repeated excluding bed size and SMSA size as control variables and using a simple urban/rural split, then the estimated relationship between costs and each .1 increase in residents per bed increases from 5.79 to about 9 percent. Some of the factors that may cause the measured association between operating costs and residents to be biased upwards are now examined.

1. **Errors in the DRGs.** The Medicare Case Mix Index used in the analysis was based on data that had been reported to HCFA in 1981—the 1981 MedPAR file. The diagnostic information reported to HCFA was often flawed,[13] and research by Pettengill and Vertrees indicates that errors in patient classification tend to compress the estimated values of the individual hospital case mix indices.[14] Thus the measured index of a hospital with a costly case mix is likely to be too low relative to its true value while the measured index of a hospital with a much less costly mix of patients will be too high. If the case mix indices of the teaching hospitals, particularly those with large teaching programs were underestimated, then some of the effect on operating costs that was in fact due to case-mix would be attributed to the resident to bed ratio.

It appears in fact that the case mix indices of many of the large teaching hospitals were underestimated.[15] Hence, if the analysis were to be repeated today, using more accurate data, the estimated statistical association between Medicare operating costs and the resident to bed ratio should decrease.

2. **DRG prices:** The current set of DRG prices (or relative cost weights) are derived using an algorithm developed by HCFA. To set prices, HCFA estimated the average cost of each DRG by adjusting the average billed charge for each DRG with information from the hospital cost reports. Essentially ancillary costs were distributed across the DRGs on the basis of charges adjusted by departmental cost to charge ratios, and routine and special care costs by their length of stay. The data bases used to calculate these prices were the 1980 Medpar File and the 1980 Medicare Cost Reports.

It is very likely that the relative prices calculated by HCFA are compressed. In other words, the prices of the high cost DRGs are low relative to the actual cost while those of the low cost DRGs are likely to be overpriced.[16] Three factors contribute to this compression. First, there is, as noted above, significant error in the MedPAR data base—thus the estimated cost of a given DRG will be based on patient charges for both patients who are accurately coded in a DRG and those who are inaccurately coded. Second, the price setting algorithm implicitly assumes that the per diem routine costs and per diem special care costs are the same for each DRG. However, to the extent that the level of routine and special care costs are affected by case-mix, this algorithm will lead to a relative underpricing of the high cost DRGs (and overpricing of the low cost ones).[17] Finally, there is considerable anecdotal evidence that, at least until recently, hospitals subsidized the prices of specialized high cost procedures.[18] To the extent this practice is pervasive, the adjusted cost for the truly high cost patients who are likely to use high cost services will be set relatively low.

The compression of the DRG prices will lead to an underestimation of the size of the case-mix index in hospitals that treat a high proportion of high cost patients while it will lead to an overestimation of the size of the case mix index in hospitals with proportionately more low cost cases. Again if the magnitude of the case mix indices of hospitals with large teaching programs are underestimated, then some of the effect on operating cost that was in fact due to case-mix would be attributed to the resident to bed ratio. Much of the source of error in the DRG prices should be eliminated if the prices are reestimated using more accurate diagnostic codes.

3. **Limitations in the DRGs:** The DRGs classify patients into one of 468 groups for payment purposes. Data used to group patients into DRGs are restricted to information that is readily available on the hospital discharge abstract.

Grouping variables include principal diagnosis, surgical procedures, complicating or comorbid conditions (based on secondary diagnoses), age and discharge status. Some of the DRGs are collections of more homogeneous patients than other DRGs. The coefficient of variation (a rough measure of homogeneity) of patient lengths of stay or charges within DRGs ranges from under .4 to over 1.6 with the coefficients of variation of the surgical DRGs being considerably smaller than those of the medical DRGs.[19] While part of the observed variation is attributable to coding errors and part due to varying levels of inappropriate care, some of it is due to the fact that some DRGs are aggregations of patients with very different resource needs. The less homogeneous the patients are within a given DRG, the more likely it is that hospitals will not get a random mix of patients within that DRG.

A number of people, including the Secretary in the *Report to Congress* and the Senate Finance Committee, argue that the teaching hospitals do not serve a random sample of patients within each DRG. They argue that teaching hospitals are likely to attract the sicker and more severely ill or the more difficult to diagnose patient. Research by Horn and by Knaus, et al provides support to these arguments.[20] However, research by Coffey and Goldfarb suggests that, based on disease staging, teaching hospitals do not treat a more severely ill patient population. To the extent that the DRGs fail to classify patients accurately and to the extent that the more costly patients within a DRG are treated by hospitals with large teaching programs, then some of the effect on operating costs that is due to patient mix will be attributed to the number of residents per bed.

4. **Factor Pricing:** The level of hospital costs is affected by the amount that hospital administrators pay for their "factors of production"—nurses, supplies, drugs, electricity and so forth. In the statistical analysis of the factors affecting Medicare costs per case, the only factor price that was taken into consideration was hospital wages—using a single wage index for an SMSA or for the rural areas of a state. However, there can be considerable variation in wages within an SMSA. The wages of workers who work in the central city are often higher than those in the suburban ring. For example, in a study of hospital costs in five metropolitan statistical areas it was found that wages were an average 17 percent higher in the county that formed the metropolitan core than they were in the suburban ring.[21] Thus, to the extent that hospitals with large teaching programs are more likely to be located in the central city, the estimated effect of residents per bed on Medicare operating costs will be slightly overestimated.

As noted above, labor is not the only factor of production which is used in the production of inpatient services. Food, energy, drugs, and so forth are also used. While some of these products are purchased in national markets, others are purchased locally. Regional price indices for factors of production other than labor are not currently available. However, cost of living indices published for the major cities indicate that the price of food and electricity vary regionally, with higher prices often found in the Northeast.[23] Given that 39 percent of COTH member hospitals are located in the Northeast compared to 13 percent of nonmember hospitals, the omission of factor prices other than labor may lead to a slight upward bias in the estimated effect of residents per bed on costs, although this bias would be very small.

5. **Indirect Teaching Costs:** The indirect costs of teaching may be defined as those additional costs that are incurred by a hospital because it is engaged in graduate medical education and because it has a large number of residents directly involved in patient care. These costs do not include the easily identifiable direct costs such as the salaries paid to the teaching physician and the salaries of residents themselves.

The true indirect costs are inherently difficult to identify—which is the reason that statistical analysis is used to estimate them. However, one major source of these costs is the increased use of ancillary services in the provision of patient care. Almost all investigators have concluded that, controlling for the patient diagnosis, more ancillary services are provided in teaching hospitals.[24] One study, for example, found that the average charge for patients with congestive heart disease was 14 percent higher in teaching units than in private units with most of the difference attributed to the increased use of ancillary services.[25] A second study found that, within the study hospital, service charges were 60 percent higher on the teaching floors than on the nonteaching floors. (The researchers believed that the patients were comparable.)[26] Still a third study, which compared patient care patterns in a teaching hospital with those of a nonteaching hospital, found that charges were higher in the teaching hospital with most of the difference being attributable to the greater frequency of diagnostic testing.[27] The list could go on.

This increased use of ancillary services is primarily due to four factors: (1) the residents' relative inexperience and the fact that some of the extra testing represents learning by doing; (2) the tendency in teaching hospitals to try to make a more accurate diagnosis for both educational purposes and to satisfy the more academically minded physicians' "need to know" even in those circumstances where treatment will not be modified by the finding;[28] (3) the increased availability of state of the art testing facilities; and (4) the fact that very sick patients may be treated much more aggressively in these institutions.[29]

The increased use of ancillary services is thus highly correlated with the number of residents per bed. However, it must be pointed out that the increased use of ancillary costs will not be directly translated into a proportionate increase in ancillary costs since the marginal cost per test is generally low.

There are no doubt other costs that teaching hospitals incur because they have large teaching programs. These include factors such as more extensive and much more expensive medical record keeping, more complete medical libraries and so forth. In addition, because they have large teaching programs, these hospitals may feel that they are under more pressure to introduce state of the art technology with its higher costs.

These five factors are not the only ones that influenced the 1981 estimated statistical relationship between residents per bed and costs, but they are surely the most important ones. Thus it is likely that, if a better case mix classification system were available, if better cost weights were calculated and if more attention were paid to the different factor markets, the estimate of the association between Medicare costs per case and residents per bed would be less than "5.79" percent. How much less it is hard to say, but it would be surprising if it fell below 5 percent.

The Indirect Costs of Medical Education Considered Further

The term "indirect costs of medical education" has become increasingly murky over time. The discussion above should suggest that there are at least three ways in which this term is used. One is a *concept* which suggests that even after the direct costs of education are taken into account, the costs of providing patient care—to similar type patients—will be higher in hospitals with large graduate medical education programs. The second is an *estimate*. It is an estimate of the relationship between costs and residents per bed after controlling for other factors that are expected to influence hospital costs. The *estimated* relationship of the pure indirect effect of graduate medical education will depend on the other variables included in analysis; both the type of variables and how they are measured.

The third is a payment which is added to the standard DRG payment in order to both pay for the indirect costs of graduate medical education and to compensate for problems with the current DRG classification system. In practice this payment also compensates for some of the limitations in the current method of adjusting for factor price differences across geographic areas. The size of the payment is related to the estimated statistical relationship between costs and the resident to bed ratio. In fact, the estimated relationship is doubled.

Under the current prospective payment system, as noted above, the adjustment is tied to the size of the relationship between Medicare operating costs per case and residents per bed obtained from an analysis in which MSA size, hospital bed size, MSA wages or state rural wages and the Medicare case-mix index are used in the analysis. The payment adjustment is obtained by *doubling* the estimated size of the relationship. With the exception of these payments, the level of the payment that a hospital receives for a given DRG will depend on its location (urban, rural) and area wages.

The design of the current prospective system and the payment adjustment for the indirect costs for medical education is inherently flawed. It is flawed first because it uses inadequate methods to adjust for differences in the economic environment in which hospitals provide care. In addition it is flawed because it ties the increased payments to teaching hospitals—payments designed to compensate them for unmeasured differences in their patient population—to the number of residents per bed and because the payment adjustment is *higher* than the estimated cost relationship between residents per bed and costs.

The design of the system leads to a somewhat inequitable allocation of Medicare payments among hospitals.

Suppose there is a large community with two 1200 bed hospitals. One hospital has 400 residents in training, while the other has 120. The first hospital will receive 20.8 percent more per DRG than the second although they are probably treating the same kinds of patients and pay the same amount for nurses, etc. On the other hand, two urban teaching hospitals located in the same MSA with the same size graduate medical program will receive the same payment per DRG although the one located in a suburban county probably faces lower labor costs than the one located in the central city.

These flaws, which have lead to a large payment to hospitals under the rubric "indirect costs of medical education," are likely to give rise to three quite different kinds of responses.[30]

First, given the intention of Medicare to limit the overall payments to hospitals, the relative financial advantage of institutions with large graduate medical education programs is likely to be perceived as unfair by other hospitals. Thus, these hospitals are likely to attack the double teaching adjustment in the same way that the Federation of American Hospitals attacked the federal Medicare waivers to the four rate setting states.[31] The reduction in Medicare payments to hospitals with large teaching programs would be offset by payments to those with none. Recently released data by HCFA is likely to encourage this response. HCFA reported in testimony to the Subcommittee on Health of the Senate Finance Committee that, "Our simulation indicates that approximately $204 per case would be withheld from all hospitals so that all teaching hospitals could receive an average of approximately $613 per case for indirect medical education."[32] These numbers, however, exaggerate the extent to which payments for indirect medical education affect the distribution of Medicare payments among hospitals for a given Medicare budget. If there were no payments for the indirect medical education adjustment, then the standardized DRG payments for all hospitals—including those hospitals with major graduate medical education programs—would increase and significantly larger DRG payments would flow to teaching hospitals, though the distribution of the payments among teaching hospitals might be different.

Second, separating the adjustment for the "indirect teaching costs" from the actual DRG rate and paying it as a lump sum makes the payment vulnerable as a source of federal budget savings. Thus it is only a matter of time before there is a pressure not only to reduce the size of the adjustment but also to coordinate the adjustment with federal manpower policies. For example, residents in specialties that are considered to be in excess supply could be eliminated from the count of residents used as the basis for the adjustment.

Third, other things being equal, residents are now a significant source of income. Given that residents salaries are included in the direct medical education pass through, hospitals may have strong incentives to try to increase their number of residents.[33] One way that a hospital can attract more residents is to increase their salaries, and thus it can be expected that there will be upward pressure on such salaries as the market begins to work. (This incentive, however, will be dampened if there is increased price competition among hospitals as a result of private sector initiative such as the promotion of HMOs or preferred provider organizations.)

A significant reduction in the size of the adjustment, however, will not eliminate those problems that generated the doubling in the first place.

The doubling arose because under the Secretary's original proposal, hospitals with large graduate medical education programs would have been disproportionately "penalized." From the perspective of time, it is clear that it is not understood that the reason for their being disproportionately penalized under that proposal was as much due to the failure of PPS to adjust for factor cost differences as it was to the inadequaceies of the case-mix classification system. One consequence of the doubling is that the "true indirect costs" of graduate medical education are exaggerated and that the political debate over the issue has become distorted.

Possible Evolution of the Prospective Payment System

In order to rectify some of the problems discussed above, it is ncecessary to make some changes in the design of the prospective payment system. These changes should make the system more equitable and help promote the efficient delivery of hospital services. It should be noted that many of the steps needed to implement these changes are already on the HCFA agenda.[34]

The first step is the most obvious one and one that HCFA can be expected to take. As soon as HCFA has at least 6 months of discharge data reported under PPS, it should recalibrate the DRG cost weights and then recalculate each hospital's Medicare case-mix index. Since the reporting of diagnostic information was meaningful during that time period, the amount of error embedded in the data should decrease. Thus the DRG cost weights should improve and the estimated individual hospital's case-mix index be more accurate. Then HCFA should reestimate the teaching adjustment factor. One would expect that with more accurate case-mix data, the estimated value of the association between Medicare costs and the resident to bed ratio would decrease.

The second step is to modify the structure of the current DRGs. Some of the current DRGs are too heterogenous to be used in a payment system. In addition, the associated failure of the DRGs to adjust for severity will become more pernicious as the hospital specific component of the prospective payment system is phased out. Two short term possibilities should be explored. The first is to experiment with modifying the current DRG system based on information from other case mix classification systems based on discharge diagnosis such as staging[35] or patient management categories.[36] Second, the phase-in period would help to alleviate problems due to the classification system only if the actual case-mix of a given hospital were reasonably stable over time. In the long run, a new approach to classifying patients may be desirable. Research on reliable methods of severity measurement and on the development of classification systems that provide more clinically specific categories should be a top priority.

The third step is to improve the method used to estimate the DRG relative cost weights. Particular effort will have to be directed towards methods for allocating the routine and special care costs across the DRGs. (The other two factors that were identified above as causing problems with the current DRG cost weights—errors in patient discharge codes and cross price subsidization—should fall in importance over time as a result of both the Medicare PPS and increased competition among hospitals due to changes in private financing.)

The fourth step is to determine why hospital costs are so much higher in the larger Metropolitan Statistical Areas. As noted earlier, controlling for wages, residents per bed and the Medicare case-mix indices, HCFA analysts found that Medicare costs per case varied significantly with the size of the urban area. They found that hospital costs in urban areas of over a million population were 10.9 percent higher than hospitals located in rural areas; while hospitals located in urban areas with 250,000 to 1 million people, and those in urban areas with less than 250,000 population were 2.6 and .1 percent respectively more expensive. Subsequent research indicated that hospital costs in SMSAs with over 2.5 million people are significantly higher than those of hospitals located in areas from 1 to 2.5 million people.[37] Some of this cost differential may be due to unmeasured case mix differences. Most however, is likely to be due to the fact that the majority of hospitals in larger urban areas are located in the central city portion of the MSA and need to spend more on security and employee wages generally. Whatever the reason, if the size of the urban area is not taken into consideration, then *all* hospitals in those areas will be relatively adversely affected. One way to adjust for those differences, would be to treat each MSA as a separate group for rate setting purposes or to expand the number of locational factors used to set the national rates from two (urban/rural) to possibly 5 groups based on SMSA size. The first approach would be administratively complex while the second would exacerbate the boundary problem (hospitals in one MSA could receive significantly lower DRG payments than hospitals in a slightly larger MSA.) A different approach would be to slow down the phase in period.

A fifth step is to improve the information on factor prices. While HCFA is already engaged in a study to improve the wage data, it should also be encouraged to collect data on other factors of production that are purchased in local areas. In addition, the relevant geographic area used to adjust for factor price differences should be reconsidered. Currently, the MSA is the relevant geographic area for determining wage differences. However, as noted above, wages in the core county are often higher than wages in the counties making up the suburban ring. If this wage differential is not taken into consideration, then hospitals located in the core county will be adversely impacted. The problem of defining the relevant market area for assessing factor price differences is especially serious. The current urban subdivisions are defined as aggregates of counties which are historical political artifacts. (Similar problems exist among and within the rural counties of states.) However the setting of different wage indices for different areas within an MSA would again create a major boundary problem. Two hospitals across the street from each other, one in the suburban ring and the other on the perimeter of the core county, could receive quite different payments for a given DRG.

Thus, there are many modifications that will have to be made in the design of the prospective payment system. The first three steps relate to changes that will have to be made in the patient classification system and the mechanism for setting relative payments. The fourth and fifth steps relate to methods for adjusting for geographic variations in factor costs that depend on location. For Medicare, a national system, at least as much attention must be given to the last two steps as to the first three. One way of underlining the importance of the last two steps is that even if it were possible to develop a perfect classification system and an accurate set of relative prices for the DRGs, hospitals in the large MSA's and in the core counties within the MSAs (many of which are teaching hospitals) would be relatively adversely impacted under a national prospective payment system as currently designed.

Hospitals with large medical education programs would be relatively adversely impacted even if they received a payment adjustment for the "true" indirect costs of medical education.

A satisfactory completion of these steps may be impossible and Medicare may seek methods of delegating the payment decisions. Two separate approaches are feasible. First, the federal government could encourage the establishment of state rate setting programs. In this case the methods for paying hospital care would be determined by the states. Second, Medicare could establish capitated systems for Medicare beneficiaries—in which case the organization responsible for providing services would also be responsible for negotiating with hospitals the amounts to be paid for hospital care. Neither of these approaches solves the problems of how to pay hospitals, but they do decentralize the decision to entities that are more able to take local market conditions into consideration.

In addition to the five steps just discussed, HCFA should undertake a study which compares the variation in hospital costs per admission with the total cost of an illness episode. It is possible that the higher costs incurred by the ancillary-intensive teaching hospital admission are offset, at least partially, by the use of fewer medical services during the illness (e.g., fewer re-admission or fewer ambulatory care services) or by fewer days of restricted activity for the patient. No study has examined the costs of teaching and non-teaching hospitals in light of the patient's total illness costs; such a study is needed and should be on HCFA's research agenda.

VI. Summary and Conclusions

The adjustment for the higher costs of teaching used in establishing the routine 223 limits was a reasonable step to take in 1980. The label attached to this adjustment, however, was misleading. The adjustment took into account not only the higher costs associated with medical education but also unmeasured cost factors that were correlated with the number of residents per bed. The continuation of an adjustment for indirect costs under prospective payment was also a reasonable step to take in 1983. However the magnitude of the adjustment made in 1983 was less justifiable and of considerably more importance to the hospital industry than the one made in 1980. It was less justifiable because it resulted from a pragmatic decision to double an estimated number, and it was of considerably more importance because the amount of dollars at issue was considerably higher.

The current adjustments are somewhat larger than would be considered equitable when the payment rates for all hospitals are considered together, and they lead to an inequitable distribution of Medicare payments across hospitals, not only between teaching and nonteaching hospitals but also across teaching institutions. However, it must be remembered that the size of the current adjustment is partly a consequence of an initial decision to take only a limited number of geographic factors into consideration in setting the payment rates.

The magnitude of the payments made under the rubric of the indirect costs of medical education is likely to make the adjustment a subject of attack by other hospitals. In addition, these payments are likely to be considered as a potential source of budget savings by the Administration and Congress. Nevertheless unless differences in the types of patients treated and the differences in factor prices in the markets where teaching hospitals are concentrated are taken into consideration, any significant lowering of the resident to bed adjustment may put a disproportionate number of teaching hospitals at significant financial risk. Innovative methods for accounting for these factors must be developed if the prospective payment system is to be sustained. This paper has made some suggestions on how to proceed.

The current experiment in hospital pricing under Medicare and the increase in competition in the private sector represent a radical change in the financing of hospital services. This is an experiment that only America has dared to try. No other country has attempted to develop fee schedules for in-patient hospital care. We are sailing an uncharted sea, and must sail carefully.

FOOTNOTES

1. Federal Register. *Medicare Program; Proposed Schedule of Limits on Hospital Inpatient General Routine Costs for Reporting Periods Beginning on or after July 1, 1980.* Vol. 45, No. 4.
2. This number was derived from information included in a statement by Henry R. Desmaris, Director, Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administrator before the Subcommittee on Health, Finance Committee, U.S. Senate October 1, 1984.
3. There was an effort to determine whether the higher routine per diem costs in teaching hospitals were associated with a more costly case-mix. This effort was not fruitful because an appropriate case-mix index was not available.
4. Federal Register. *op. cit.* p. 21584.
5. Alternatives considered and rejected included paying teaching hospitals the same DRG rate as nonteaching hospitals, making the indirect Graduate Medical Education (GME) adjustment a function of the direct GME pass through payment and setting a flat rate per resident per bed.
6. Secretary of Department of Health and Human Services. *Hospital Prospective Payment for Medicare: A Report to Congress.* Washington, D.C., December 1982, pp. 47-48.
7. *Ibid.* pp. 48-49.
8. The actual estimating equation is:

$$\mathrm{lnCPC} = 7.32 + 1.011\ \mathrm{lnCMI} + \underset{(29.63)}{1.022\ \mathrm{lnWage}}$$
$$+ \underset{(12.72)}{.579\ \mathrm{lnR}} + \underset{(24.43)}{.119\ \mathrm{lnBeds}} + \underset{(.58)}{.0007\ \mathrm{SCV}}$$
$$+ \underset{(5.29)}{.026\ \mathrm{MCV}} + \underset{(60.67)}{.109\ \mathrm{LCV}} \qquad R = 75$$

Where

CPC is the Medicare operating cost per case; CMI is the Medicare case-mix index; wage is the wage index; R is Residents per bed; beds is hospital bed size; SCV is urban area with a population of less than 250,000; MCV is urban area with a population of 250,000 to 1,000,000, and LCV is urban area with over 1,000,000 population and ln represents natural logarithm.

9. Senate Finance Committee Report. *Social Security Amendments of 1983.* Report No. 98-23. Washington, D.C. March 11, 1983 p. 52.
10. Department of Health and Human Services, Health Care Financing Administration. "Medicare Program: Prospective Payments for Medicare Inpatient Hospital Services, Interim Final Rule with Comment Period." *Federal Register,* Thursday, September 1, 1983, p. 39778.
11. These results are given in footnote 8 above.
12. The reason for this is quite technical. Statistically, if there is a variable that is excluded from the model that affects hospital costs, and which is also directly related to one of the variables in the model, the coefficient of the included variable will be biased upwards to include the effect of the omitted variables.
13. The Institute of Medicine estimated that approximately 20 percent of the records in the file used by HCFA to construct the case-mix index had an erroneous principal diagnosis at the DRG level. Institute of Medicine. *Reliability of Medicare Hospital Discharge Records.* National Academy of Sciences. NTIS. PB 281680, November 1977.
14. J. Pettengill and J. Vertrees. "Reliability and Validity in Hospital Case-Mix Measurement." *Health Care Financing Review* 4 (2), 1982: 101-127.
15. Personal Communication, James Bentley, Department of Teaching Hospitals, AAMC.
16. Judith R. Lave. "Note on the Compression in the HCFA DRG Prices." Unpublished paper, University of Pittsburgh, 1984.
17. Work by Fitzmaurice indicated that routine per diem nursing salaries, a major component of routine costs per day, are significantly related to the Medicare case-mix index. See M. Fitzmaurice. "A Statistical Analysis of the Medicare Routine Nursing Differential." *Health Care Financing Review.* 5 (1) 1983: 45-64. Additional evidence on this issue is presented in J. Thompson. "The Measurement of Nursing Intensity." *Health Care Financing Review.* In press.
18. Office of Technology Assessment. *Diagnosis Related Groups and the Medicare Program.* Implications for Medical Technology. Washington 1983.
19. Unpublished data. Bureau of Data Management and Strategy. HCFA.
20. S. Horn. "Measuring Severity of Illness: Comparisons Across Institutions." *American Journal of Public Health.* 73(1), 1983:28-31. E.A. Draper, D.P. Wagner, and W.A. Knaus. "The Use of Intensive Care: A Comparison of a University and a Community Hospital." *Health Care Financing Review.* 3(2), 1981:40-64.
21. R. Coffey and M. Goldfarb. "DRGs and Disease Staging for Reimbursing Medicare Patients." Working Paper. National Center for Health Services Research, 1984.
22. J.L. Ashby. *The Inequity of Medicare Prospective Payments in Large Urban Areas.* District of Columbia Hospital Association. September 1984.

23. J.R. Lave. "Hospital Reimbursement Under Medicare." *Milbank Memorial Fund Quarterly.* 62(2), 1984:251-268.

24. The one exception is a paper by Becker and Sloan which reported no difference in the use of ancillary services between teaching and nonteaching hospitals. See. E. Becker and F. Sloan. "Utilization of Hospital Services: The Roles of Teaching, Case-Mix and Reimbursement." *Inquiry.* 20(3), 1983:248-264.

25. M.L. Garg et al. "Reimbursing for Residency Training, How Many Times." *Medical Care.* XX(7), 1982:719-726.

26. E.W. Martz and R. Ptakowski. "Educational Costs to Hospitalized Patients." *Journal of Medical Education.* 53(May) 1978:383-38.

27. S.A. Schroeder and D.S. O'Leary. "Differences in Laboratory Use and Length of Stay Between University and Community Hospitals." *Journal of Medical Education.* 52(5), 1977:418-420.

28. D.B. Reuben. "Learning Diagnostic Restraint." *New England Journal of Medicine.* 310(9), 1984: 591-593.

29. A. Garber, V. Fuchs and J. Silverman. "Case Mix, Costs and Outcomes." *NEJM.* 310(19), 1984.

30. Some of these same issues are described in M.E. Whitcomb. "The Federal Government and Graduate Medical Education." *The New England Journal of Medicine.* 310(20), 1984:1322-1324.

31. Federation of American Hospitals "Potential Inequities of Medicare Waivers" Statement. No date. Washington, D.C.

32. Henry R. Desmaris. *op cit* p. 8.

33. J. Newhouse "Two Prospective Difficulties With Prospective Payment for Hospitals, or It's Better to Be a Resident Than a Patient With a Complex Problem." *Journal of Health Economics.* 2(3), 1983:269-274.

34. S. Jencks et al. "Evaluating and Improving the Measurement of Hospital Case-Mix." *Health Care Financial Review.* Annual Supplement. 1984 in press.

35. J.S. Gonnella, M.C. Hornbrook and D.Z. Louis. "Staging of Disease: A Case Mix Measurement." *JAMA.* 1984.

36. W. Young et al. "Hospital Case Mix: Development and Implementation." Health Care Research Department, Blue Cross of Western Pennsylvania. Pittsburgh 1983.

37. G. Anderson and J. Lave. "The Costs of Teaching Hospitals." Work in Progress.

Mr. Frost. Can you briefly summarize how your hospital has done under the DRG system and compare your current financial system to what it was prior to the implementation of the DRG system?

Dr. Buck. Yes, sir; we believe that we are getting slightly more reimbursement than we would have under the previous reimbursement system. That was in year one. That would not be the case in the second year of the program, due to inflation. We will be getting less in the second year of the program than we would have under the cost-based reimbursement system.

Mr. Frost. Because of the freeze?

Dr. Buck. Yes.

Mr. Frost. At least during the first year, your hospital did not suffer under the system?

Dr. Buck. That is correct, and I am not suggesting that we have. What I am suggesting is that there is so much error in the system, as indicated by the fact that we only can explain about two-thirds of the cost variation among hospitals. We did not suffer in the first year because our current reimbursement is so dependent on our own cost base and there are all of the other vagaries of the calculation, that it just turned out that way.

I am only suggesting if we continue to freeze and freeze and freeze, without improving our ability to identify those variables we do want to pay for, we will be making a major mistake.

Mr. Frost. When Mr. Haddow of HCFA was before us last week, he said he felt that there should be a freeze again next year, and there ought to be some consideration given to actually reducing the amount.

I don't think he was advocating that before our committee, but he felt hospitals were doing very well under the DRG system, and he didn't see the need for any increase in the amount that they are receiving this year or next year.

Dr. Buck. My position is what I just said. We are flying blind, and we can squeeze and squeeze and squeeze, and then a certain set of hospitals will get hurt.

To the extent that we drive out inefficiency, we are all for that. To the extent what we drive out is those hospitals that are large inner city hospitals that take care of a disproportionate share of the poor, that is not good. To the extent we drive out the teaching hospitals that take care of a large proportion of the burn victims, and other people referred from other hospitals to our centers, that is not good.

To the extent that we are regionalizing care, as I talked about for the cardiology patients, that is good, and to drive that out is not good. We need measures for each of these functions so as we squeeze the pie, we can be more certain that we are squeezing out only inefficiency and not things that we do want our hospitals to do.

Mr. Frost. Also during his testimony—and I alluded to this earlier—Mr. Haddow said that the reason the administration had not proceeded with implementing the disproportionate share adjustment was the difficulty in arriving at an adequate definition.

I asked this earlier of Dr. Anderson. Do you agree with Mr. Haddow that it has been hard to come up with an adequate definition, and that was a reason for not implementing this particular adjustment?

Dr. BUCK. As a regulator in Maryland, I was faced with such issues all the time. I do not agree. Let me give you that answer. I agree with Dr. Anderson. ProPAC, and others are making very good progress on identifying an appropriate measure.

We made a huge fundamental decision with this system to go to per case prospective reimbursement. Admissions are down; length of stay is down like crazy, and that is good. We should be very careful, however, and mindful that we don't know the right amount to pay. We have everything going in the right direction. Let's not mess it up by getting too restrictive. Let's develop measures for those other products that I think you and society want hospitals like ours and Dr. Anderson's to provide.

Let's measure them, and when we can explain—I may live to be sorry I said this, but—when we can explain 90 percent of the cost variations or a number like that, in terms of variables that predict legitimate services, let's go with national rates and assume that the other 10 percent is inefficiency. We will live with that. But when the unexplained variation is 33 percent, I think it is just outrageous to simply squeeze hospital payments.

It isn't right to assume that whole gap is inefficiency.

Mr. FROST. Relationship between the indirect teaching adjustment and the disproportionate share adjustment, and you said some, but not all, could be offset between these two.

Are you talking about an individual hospital that might qualify for both, or the general category of indirect teaching adjustment and the general category of disproportionate share adjustment?

Dr. BUCK. The way it would be calculated, the resident to bed ratio, we are talking about an aggregate. If you calculated the disproportionate share adjustment first and took that variation out of the system and then recalculated the indirect teaching adjustment, that adjustment just statistically or mathematically would end up going down.

Mr. FROST. If a hospital were receiving both? That is my question.

Dr. BUCK. I am talking about an aggregate. You would turn around then and apply those factors to each hospital, because they are not exactly the same. They do measure different things.

All I am saying is that there is, statistically speaking, covariance. There is some covariance in those variables, and it is reasonable that the amount of overlap be taken out of the indirect passthrough total pot.

Mr. FROST. I understand, but my question is, the particular hospital, the urban, center city hospital that is a teaching hospital. Would it lose some of its indirect teaching adjustment if it received the full disproportionate share adjustment?

Dr. BUCK. Depending on how the calculation is carried out, yes, you could think of it that way.

Mr. FROST. It is likely that the administration will make some recommendations next year for further cuts in Medicare, and assuming that the Ways and Means bill becomes law, and we have a disproportionate share adjustment, it is possible the administration will come in and ask us to decrease the indirect teaching adjustment substantially. And they certainly sought a reduction in the indirect teaching adjustment this year, even without the implementation of a disproportionate share adjustment.

Dr. BUCK. As you said, you, of course, are cutting it this year. I still come back to the same issue.

As long as the ratio of residents to beds explains a significant amount of cost variance among hospitals, and as long as you believe, as I do, that this is a pretty good proxy, for several important functions that we perform and for which we really should be paid, it ought to stay in.

It is a matter——

Mr. FROST. Indirect teaching adjustment?

Dr. BUCK. Yes, it is almost as if we were the president of General Motors and we were told that Chevrolets cost us $4,000 plus or minus $1,000 to make in plant A and $6,000 plus or minus $1,500 in plant B. Now try to set fair and adequate prices. We are flying blind with huge unexplained variations. We are setting prices on which we expect hospitals to operate. I mean, I wish I knew the numbers, but the variations within DRG's are in the range of plus or minus 20 percent.

My hospital operates on a 3-percent margin. All of that does not become a problem until the whole set of squeezes reduces that amount of money available to where it raises these issues.

I am suggesting—we have got to put the other side of the equation in place, the adjustments that can measure legitimate products.

Mr. FROST. Mr. MacKay.

Mr. MACKAY. Dr. Schramm seemed to be saying on the one hand, we need to play by the rules and don't freeze things, and go on and allow increases if the formula shows it, whether or not we made a mistake at the outset. And he seemed to be saying we are going to discredit the system long-term if we attempt to take advantage of cost savings that might be available short-term, and he seemed to be saying that we can't really tell whether these savings are real because some is a cost shift because we didn't include everybody in the system.

You seem to be saying, on the other hand, that we should go very slowly, because we are squeezing down and we don't have a road map, and we should not go further faster until we can explain some of what is going on.

Now, I am a layman, and I believe the problem is not that we can't explain it. The problem is that you have got too many ways to explain it. Are you saying different from Dr. Schramm?

You have a commonality of background. Do you reflect a difference of opinion?

Dr. BUCK. We never have agreed on everything.

Obviously, if the Congress decided to go ahead with the market-basket inflation, you won't have us here opposing it but I don't think in the long run that is the issue that will maintain the credibility of this system.

You say we have a lot of ways of explaining the variation. You are right, we do. The question is, which of those things which we do, do you or society want us to continue doing. If you don't want us to do those things, don't pay us for them, and we will stop doing them. For many of the functions I have listed that is not what I think society really wants. Those are things, which are in that 33 percent that we can't predict, and we can't explain.

They are quantifiable or at least roughly estimatable, and we need to do that. I would lose more faith in the system if we don't start doing that than I would by the fact that we are going to roll back a bit on the overall inflationary increase. The adjustments are where you will show that you recognize and want hospitals, especially teaching hospitals, to continue to perform these valuable services. You will show that you recognize some of the things these hospitals do are not going to be covered by a national rate, and that you want them to keep doing them. From my point of view, I would be more alienated and feel the confidence was broken more by not pursuing an explanation for those other products. I would object more to the ignoring of the other products than I would to the issue that Dr. Schramm mentioned. He suggested that we need to regulate everything in order for the system to work. I have gone through a cultural change moving from Maryland to Pennsylvania. I would disagree with him.

I think a regulated system can work, and I was very proud of my role in the Maryland system. I do not have the confidence that Maryland's system can be replicated across the country.

It was developed with very special history, a very special set of people and in a liberal State with an ability to implement a regulated scheme. On the issue of excess capacity, all you have to do to determine whether regulation or competition works better in eliminating excess capacity is to get on an airplane today and remember what it was like 3 years ago. Competition squeezes out excess capacity, and I agree with Dr. Schramm that excess capacity is a major issue.

In Maryland they have now identified the need to reduce excess hospital beds, as we have known they would. I would bet a nickel which approach will actually get excess capacity out of the system fastest. Already in Maryland, and it is very understandable, the community outcries have been heard. Some are suggesting "let's shrink every hospital a little bit," rather than eliminating whole hospitals. It is the post office phenomenon, in which each town wants its own—its own post office and its own hospital. Dr. Schramm and I don't agree on several issues.

Mr. MacKay. You believe it is possible for Medicare to operate under a PPS in effect as one payor while the rest of the system is operating under a different one?

Dr. Buck. I think that is possible.

Mr. MacKay. Don't you think that is going to screw up the rest of the world?

Dr. Buck. Only if the——

Mr. MacKay. For instance, let me take Florida where Medicare is 60 percent of everything. You have a very small field in which to shift anything.

Dr. Buck. I am not suggesting—see, here is the problem. If Medicare decides to buy on the margin, we have a real problem. Back in TEFRA, it said the Federal Government can buy on the margin. I do have a problem with that.

That forces all these issues, and if every payor tries to buy on the margin, the additional adjustments I talked about won't matter then. If you want to buy the least cost medical care with hospitals in this country running low occupancy, you can get a heck of a deal. Like in California, you can aggregate Medicare patients in low cost hospitals and buy each unit of care less expensively than you would under a cost reimbursement system, but if you do that, then I have serious problems, because then the system will fall apart.

I am suggesting that Medicare should pay the reasonable cost of care for the Medicare patients and some of these things I have talked about. It should not pay for inefficiency, but if HCFA goes beyond that, and has the legislative freedom to go beyond that, to essentially buy on the margin, then we have serious problems ahead of us. So whether the willpower——

Mr. MacKay. I may be putting 2 and 2 together and getting 5.

I go to some meetings where I hear glowing reports of what we are going to accomplish by having big employers get together, maximize their buying advantage and buy on the margin, and that is in the other system.

Dr. Buck. Right.

Mr. MacKay. You are saying we, the biggest buyer of all, should not do that?

Dr. Buck. The Government has a public responsibility to think beyond just purchasing at the lowest possible cost.

Mr. MacKay. What other responsibility do we have?

Dr. Buck. Services. I am still corny enough to think that the health care system is largely a service industry. We have a responsibility to provide services to the people in the country.

If you take the competition model all the way to its end, and everybody buys on the margin, a lot of those service aspects of the system will dissipate.

If three McDonalds exist in a town, and one gives away 10 percent of its food, another one decides to do some research on more nutritious meals and incurs costs for that research, and the third one says, "I am going to sell as cheaply as I can," the third one is going to thrive and the other two will go out of business.

Mr. MacKay. If I am the biggest buyer of hamburgers in the world, and everybody else organizes and buys as cheaply as they can, and I say, "Well, regardless of what that does to the system, I will continue to buy based on all these other things," it will work both ways. We are going to end up with a reverse shift.

There may be some poetic justice in that?

Dr. Buck. Again, I guess—you have the power to determine the equilibrium point in the system, where it all settles out.

If you go all the way with your purchasing power to buy care in the cheapest way that your power will allow you will have an enormous effect on the distribution of services, the other products we provide, et cetera.

I think you can pick some middle ground and hopefully calibrate that in a way that allows the system to continue that allows the special things, the service aspects of the health care system to continue and at the same time promotes competition, and efficiency coming from, for example, employers and the other purchasers of care who will be purchasing for more and more efficiency.

If that doesn't work, we are back where Dr. Schramm was with proposing an all-payer system. I have seen enough of competition, having moved from Maryland to Pennsylvania, to believe that there are enormously positive aspects to it. It is not terribly harmful now because of what Mr. Frost pointed out about our bottom line and other hospitals.

When you have me back in 5 years, and if I am losing a whole lot of money, we won't be doing a lot of the things that we do now. We will try to do them as long as we can, but eventually we won't be able to do them. That is not good for us, for you, or the country.

Mr. MacKay. This is a fascinating dialog, but I am getting some nonverbal signals.

Mr. Frost. We have two other witnesses, and we want to give them the full opportunity because they both have interesting statements. We really appreciate the testimony and your appearance today. Hopefully you will be invited back and maybe it won't be 5 years from now.

The next witness is Patricia Davis of Humana Hospital, Huntsville, AL, the executive director of that hospital. She is appearing on behalf of the American Federation of Hospitals. I would ask, to the extent that you can, to summarize your statement and then we will have a number of questions for you.

STATEMENT OF PATRICIA DAVIS, EXECUTIVE DIRECTOR, HUMANA HOSPITAL-HUNTSVILLE, HUNTSVILLE, AL, ON BEHALF OF THE FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY MARY R. GREALY, EXECUTIVE COUNSEL, FEDERATION OF AMERICAN HOSPITALS

Ms. Davis. As you said, my name is Patricia Parker, executive director of Humana Hospital-Huntsville. This hospital is a 323-bed acute care facility. It is a community hospital, and I would like to state also that I have been in the health care business now for many years. First of all, with the background in nursing, and second of all, a background in hospital administration, and prior to my moving to Huntsville, I was executive director of Humana Hospital-Audubon in Louisville, KY, the hospital where we did do the artificial heart.

I am very pleased to be here before you today, and to present views on behalf of the Federation of American Hospitals concerning the prospective payment system, as well as some of the proposals for future changes. As I have been sitting here listening to testimony today, I could not help but think back about how we got to the point of where we are.

First off, I don't remember the exact date, but I think it was somewhere around 1949 or 1950, with the passage of Hill-Burton legislation, and also then moving on up to the passage of Medicare legislation in 1965. I think at that point in time, as I think back, we began or we started out with the idea of developing one of the finest health care systems in the country, and I think we have certainly achieved that. There is no doubt in my mind about that, and I think obviously as we have progressed along that trail, the big thing that has come before us with the big problem that we are trying to handle right now and to talk about what has happened as far as the cost of health care is concerned.

From 1981 to 1983, the Nation's hospitals, all the hospitals in this country, have absorbed over 50 percent of the Medicare cuts during that period of time. At the same time, I think there is no doubt in my mind about the effectiveness of the prospective payment system as it was designed.

I think clearly it is working, and clearly I want you to understand that I am certainly in support of the system as it is designed, but I think the important thing for everyone to remember is that when we started with that system, we started out with the understanding that we would have fair increases based on the market basket, as we progressed with the system, and that we would have a technology factor, because I think we have come too far in this country not only with technology but certainly with research and development as it relates to the care and treatment of disease that I don't feel we want to give up on that.

Prior to prospective payment, hospital costs were escalating at the rate of 17 percent a year on an annual basis. In 1984 we were able to hold that rate of increase to 4.5 percent, which is clearly right along the line with inflation during that time. So, as I said before, I don't think there is any question that prospective payment is working. But now obviously with the need for budget cuts, I think the question is certainly at this point, will Congress maintain the good faith effort to live up to the commitment that we started out with, with a prospective payment system, as I alluded to earlier.

If Congress and the executive branch in essence imposes a disproportionate share, then my real concern is are we going to have a breach of faith on the part of Congress, and are we going to underman a successful system that we have right now. With no increase projected for fiscal years 1986 and 1987, the impact of such action would certainly be, I feel, detrimental, and obviously would vary according to different hospitals. I think every hospital has to do what they have to do, if they know they only have a certain amount of money.

For example, this past year, obviously we made some drastic changes, I feel, in order to respond to the prospective payment system, and one of those changes was the elimination of over 100 jobs within the facility. Again, I don't think there is any question that if we freeze payments within the system, that we are going to be looking at a reduced force.

We are going to be looking at reduced wage increases that normally we would expect for employees, and I think as you obviously know, if you start freezing wages, if you end up having less than normal wage increases expected by employees, that soon we are going to end up with people questioning whether or not they want to pursue the health care profession.

We are going to end up I think being short of some real qualified people within the health care delivery system, and as such, I think what we are going to end up having happen is that we are going to have health care provided by people that are not fully trained and qualified to do so, or certainly not with the qualifications that we have today.

We are going to see a postponement, I think, in the modernization of our facilities, and I think really keeping our facilities in the physical condition that they need to be. Forty percent of our hospitals in this country today are at least 30 years old, and I feel like I am fortunate to have had the opportunity. The hospital that I am currently executive director at is 15 years old. I was there when the hospital opened, and I certainly have been able to see the changes that have occurred to the facility through the years, and I think it is very important to realize that we have got to continue to have some money available to modernize our facilities.

We obviously can make the decision to postpone or eliminate services, as Dr. Buck was saying. The gentleman from the Joint Commission had commented about the elimination of some services like occupational therapy and like physical therapy, and I don't think there is any question about that. I think that decision will come.

Obviously, hospitals may end up making decisions to increase charges to Medicare patients on some of the items right now that the prospective payment system does not cover. There is going to be increased pressure, certainly, placed on physicians, and again I am not certain, I mean it is not a question of not being certain, but I think the important statement to make is that hospitals certainly aren't in the practice of medicine, and I think that those certainly with the prospective payment system, there is no doubt that we have been able to reduce the length of stay.

I think at the same time we have certainly, no doubt in my mind, encouraged or have made physicians aware of the need to pay close attention and to ask lots of questions, and to do lots of things on an outpatient basis prior to bringing people into the hospital. This is certainly important, but I think there is only a limit by which we can do that.

I think right now we have the real danger of destroying a successful system when we are actually making progress, and I don't think there is any question at all in anybody's mind that if you decide to put a freeze on this year, and if you decide to put a freeze on the following year, I mean, obviously, if you give me $100 to spend for Christmas to go Christmas shopping, and you give me $100 for 5 years in a row I am going to spend that and nothing else. So there is no question that the cuts can't be made, but I think the question is are you going to be satisfied, and I think we have to remember are the citizens of this country going to be satisfied with that level of care.

I think that is what we started out to do, was to have a health care system that we could all be proud of, but I think you and I both will not hesitate to say if we get sick we want to know that all of the services possible are available for us.

Another issue that I would like to comment about for just a few moments is that one of uncompensated care. I think certanly there is no question at all that when you look at the burden that uncompensated care has placed on community hospitals today, that it actually exceeds somewhere around $6 billion. The investor-owned industry assumes $400 million of that total, which represents about 4 percent of our total revenues, but I think the policy question really is whose responsibility is it to finance this needed care.

Our industry believes that Government has a proper role as the provider of last resort for the poor. Hospitals are not the source of the problem. We feel this is a critical national issue. A tax on hospital net revenues as some States have already imposed is not an equitable way to meet society's responsibilities. I feel strongly that what we are saying when we look at developing a system like that is we are saying we are going to let the people that are sick, the people that are using the services in the hospital, be then responsible for paying for those people who are ill, but who cannot afford to pay.

I think the source has got to be broad based. It has to be from all the people in order to assure adequate funding.

Alternatives to a freeze in hospital payments and congressional cuts, I think we can certainly look at extending the cigarette tax rates with part of the revenue being earmarked for the trust fund. I think we can relate the Medicare Part B premium to income by imposing a variable tied to income, or we can tax Medicare benefits of beneficiaries with incomes in excess of $25,000.

In summary, I would like to say that I feel very strongly that hospitals have responded. We have in essence done the job that you have directed us to do. We have through improved management technologies, and I think through improved working relationships with the physicians and with all health care providers, we have met the challenge that you have given to us, but I think further reductions may change how well health care is delivered, and I think that is the real question today, and the question that you have to ask yourselves. Are you prepared to change the health care delivery system that we have today.

I think we need stability. You know we went for almost 20 years with no changes at all in the system, and now all of a sudden, with the implementation of a good program, I don't think there is any question about that, but now all of a sudden, with that change, now every month we feel that there is somebody else out there chipping away, and I think what we need is some stability.

We need some time to evaluate where we are, and more importantly than that, I think we need some flexibility. I think it is absolutely ridiculous to think of doing anything with the hospital beds, the excess hospital beds we have today, other than to leave the hospitals the responsibility right now of using those in a manner in which they see fit, that is, I mention this from the standpoint of the swing bed concept, because I think it makes no sense at all to think about building additional nursing home beds when we could easily use the excess beds for this market.

But what we need now is stability. We need some flexibility to give hospitals the opportunity to see what solutions they can come up with, and more importantly, I think what we need from Congress is a commitment to quality.

We need you to feel confident in our system. We need you to feel confident that we are capable with the directions that you have given us at this point, and with the dollars that you have given us, that we are capable of taking care of the people in this country. Let's don't undermine a program that is working.

I will be happy to answer some specific questions.

[Testimony resumes on p. 213.]

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF PATRICIA DAVIS

Mr. Chairman, I am Patricia Davis, Executive Director of Humana Hospital - Huntsville, a 315 bed acute care investor-owned hospital, in Huntsville, Alabama. I am pleased to appear before you today to present views on behalf of the Federation of American Hospitals concerning the Medicare hospital prospective payment system and proposals for future changes.

The Federation of American Hospitals is the national association of investor-owned hospitals and health care systems represents over 1,200 hospitals with over 140,000 beds. Investor-owned management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

The investor-owned hospital industry is willing to accept its fair share of responsibility in any attempt to reduce the Federal deficit. However, the cuts for the Medicare program supported by the Administration go far beyond any sense of fairness and proportion. The proposed reductions in Medicare both by regulation and legislation are far greater than those suggested for any other federal program-- nearly $20 billion. Consequently, health care providers are being asked to absorb much more than their fair share of the reductions.

The Administration and Congress should note that the Medicare Hospital Insurance Trust Fund does not contribute to the Federal deficit. Payments to hospitals under Medicare do not come from general revenues; they are financed by a payroll tax. A severe reduction in payments however, will force hospitals to consider reductions in services.

The pending bankruptcy of Medicare can no longer be held out as a legitimate reason for drastic cuts in the program. The projected date for the insolvency of the Medicare Trust Fund is now beyond 1998, eight years beyond last year's projection--primarily because hospital cost increases are dramatically lower than projected levels.

During the period 1981 to 1983, the nation's hospitals absorbed over 50 percent, approximately $10 billion, of all the Medicare cuts enacted by Congress. Last year's Deficit Reduction Act contained further substantial decreases in Medicare payments to hospitals. Simultaneously hospitals came under a tough new "prospective payment" system encouraging a new cost cutting competitive spirit in the health care market place.

Hospitals have responded to these cutbacks by saving the Medicare program literally billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price. Previously hospital costs were increasing at annual rates of increases as high as 17 percent. However, this is no longer the case. Due to the more careful management of admissions, labor costs and utilization of facilities, the hospital industry has succeeded in bringing hospital costs down dramatically. In 1984, the annual rate of increase was only about 4.5%, or approximately the same as the general inflation rate.

Clearly, the Medicare hospital prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal 1984, for example, actual Medicare Part A spending was $2.2 billion or 6% less than originally projected by the trustees of the Hospital Insurance (Part A) Trust Fund.

Hospitals have demonstrated that with appropriate incentives, they will vigorously cut costs, but there is a problem. While they understand the need to accept their fair share of budget cuts, many hospitals question whether the federal government will make a good faith effort to live up to its commitments. When the Social Security Amendments of 1983 (PL 98-21) were passed, hospitals were told that:

> o they would be paid a fixed price per diagnosis and would be allowed to keep the difference between their cost and what they were paid.

- their payment rates would be increased annually by the increase in the cost of their inputs (the hospital market basket) plus 1% for technology upgrading.

Congress in the Deficit Reduction Act of 1984 (PL 98-369) reduced the technology factor to .25%. At the same time, the Department of Health and Human Services (HHS), by regulation, limited the annual increase in hospital payments to the actual input cost increase, the market basket, minus 1.05% on the theory that hospitals were reporting an unjustifiable increase in the number of higher complexity and therefore higher paying cases. Hospitals argued that the more complex case mix was the result of more accurate coding and was a one time phenomenon. Now for fiscal 1986 HHS is about to implement an administrative freeze on payment rates to hospitals.

Recently, the House Ways and Means Committee approved a 1% increase in hospital payments, while the Senate Finance Committee approved an increase of only one-half of one percent. Neither action represents a fair nor adequate rate of increase. If Congress and the executive branch impose a disproportionate share of the burden of budget cuts on hospitals, it will represent a breach of faith on the part of the Administration and Congress. It will undermine a successful program and discourage hospitals from working with their staffs, physicians and patients to continue their efforts in adapting to the new system. Hospitals will be forced to cut the intensity of service to Medicare beneficiaries or to adopt a more confrontational posture. Cooperation, essential to patients' receiving the greatest value for the dollar, will be replaced by mistrust and acrimony.

Congress as part of the prospective payment legislation, created the Prospective Payment Assessment Commission to avoid the conflict of unreasonable demands for payment on the part of hospitals and inappropriate budget slashing on the part of the Administration. Consequently, we feel Congress should consider the increase in hospital payments recommended by this independent commission as a floor on payment rates. Congress should also prohibit the Administration from administratively reducing rates below a legislated level.

If there is no increase or a minimal increase in hospital payments for fiscal years 1986 and 1987, the impact of such action would vary according to individual hospital costs. The loss of the anticipated (approximately 5%) increase in payments will force hospitals to review the following options in the order presented:

- Reduce work force

Labor costs comprise 50 to 60 percent of hospital budgets. Hospitals have already reduced their workforce by 100,000 employees, down from 3 million. Such a reduction will not be easy to implement again and could adversely affect quality and quantity of nursing care and personal attention to patients. Hospitals to meet these cost restraints may have to turn to employees with lower level qualifications, to perform more services.

o Reduce normal wage increases

If hospital payments are frozen, the adverse impact on employee wages is inevitable. Hospitals also will risk losing qualified employees to other industries not subject to such frozen prices and able to pay competitive salaries.

o Postpone Modernization of Hospital Plant

Hospital plants are aging. Forty percent of all hospital beds are at least 30 years old. Hill-Burton grants are no longer available. Although capital costs are still paid by Medicare on a pass-through basis, payments for operating costs would be frozen under the Administration's budget. Hospitals therefore cannot incur additional operating costs associated with upgrading their facilities. Furthermore, lending institutions, given the proposed freeze in hospital payments will be less likely to lend hospitals money when there appears little certainty about their long term ability to receive a fair and consistent payment from government programs.

o Postpone Replacement of Obsolete Equipment and Purchase of New Technology

As stated previously, while capital costs continue to be cost reimbursed, operating costs generated by those capital expenditures are paid prospectively. The administration's proposed freeze in hospital payments will result in the decision by hospitals either not to purchase new equipment, or to postpone such purchases which will result in later higher expenditures.

o Postpone or Eliminate Services

Hospitals will have to postpone new services or eliminate certain community services which may not prove cost effective, such as neonatal units and burn units. Essentially, some hospitals will have to change the way they currently provide healthcare.

o Reduce Supply Inventories

Hospitals have already altered their purchasing and inventory patterns. This has resulted in significant financial pressure on hospital supply companies.

- Increase Pressure on Physicians

Hospitals will encourage physicians to further reduce patient lengths of stay by ordering more pre and post admission procedures. While the recent GAO report on early discharge of Medicare patients to post hospital care, may have been blown out of proportion, the danger of premature discharges cannot be ignored.

- Increase Prices to Non-Medicare Patients

While in the past, many hospitals absorbed cuts in government programs by charging more to private paying patients, such activity is impossible in the current competitive environment. Private insurers and employers will no longer tolerate increases in premiums resulting from this type of cost shift. Consequently, most hospitals will have to cut labor costs and services to maintain their financial viability.

- Increase Charges to Medicare Patients

Hospitals will have to consider increasing charges to Medicare patients for non-covered services such as television and telephone. Hospitals will also have to analyze their legal rights to charge Medicare beneficiaries for the cost of new technology or inflation, not recognized by Medicare.

All of these options have in common, difficulty of implementation, danger to quality, and unfairness relative to the rest of the economy where there is no price freeze. Also there exists the danger of destroying a successful new set of incentives just when significant progress is being made.

Another issue of great concern to all hospitals is that of uncompensated care. Moving from a cost based to a price based system is causing a change almost overnight in the way hospitals do business. Purchasers of health care also play a significant role in this revolution by now demanding more cost effective and efficient care.

Price competition has made it difficult for private hospitals to continue cross-subsidizing indigent care. Private payers, employers and business coalitions have mounted increasing resistance to paying for uncompensated care through this cross--subsidy. The total uncompensated care burden on community hospitals exceeds $6 billion. The investor-owned sector of the hospital industry assumes over $400 million of that total, representing over four percent of revenues, approximately the same percentage as non-profit, non-public hospitals.

The basic public policy question is whose responsibility is it to finance this needed care? Our industry believes government has a proper role as provider of last resort for the poor.

The public hospital has historically filled that role as an arm of government but adequate funding is not being appropriated and more efficient delivery of care must be assured. The tax revenue to finance indigent care should be broadly based because society as a whole should meet its responsibility to care for the disadvantaged.

Ideally, we would urge a federal block grant program to provide funds to the states based on their economic needs. While the federal budget deficit makes such a new program unlikely, this is a priority issue and perhaps other federal grant programs could be expanded to cover indigent care. Since such a high percentage of indigent cases are related to maternity care, broadening the maternal and child health program could be a logical start.

Since the federal income tax law subsidizes employer purchased health insurance without limit, a tax-free fringe benefit which primarily helps the middle class, a cap on this benefit could provide new federal revenues for an indigent care program.

The tax subsidy, now estimated at over $30 billion, represent substantially more than the federal government spends on Medicaid.

Several states are considering options for financing indigent care. One option is to increase Medicaid eligibility or add a medically needy benefit. This option attracts federal matching funds. Another option is to generate new state revenues through alcohol, tobacco or property taxes, or an excise tax on private health insurance plans. Florida last year passed a tax on hospital net revenues; however, we believe this type of tax on a limited provider group is not an equitable way to meet a societal responsibility. We believe the source of financing should be much broader-based, from all the people in the nation or all the citizens of a particular state to assure adequate funding and a sharing of the responsibility.

We strongly support the current evolution of the health care system towards competition based on price and quality. However, to foster this environment we must make solving the indigent care problem a national priority; it must be financed in the broadest way, preferably at the federal level or next at the state level.

We believe there are viable and appropriate alternatives to the Administration's proposed freeze in hospital payments and Congressional cuts in the Medicare program:

o Extend the current cigarette excise tax rates with part of the revenues earmarked for the Medicare Hospital Insurance Trust Fund.

o Relate the Medicare Part B premium to income by imposing a variable Part B premium tied to income.

o Tax Medicare benefits of beneficiaries with incomes in excess of $25,000 ($32,000 per couple) similar to the recently enacted tax on Social Security benefits.

Pretending that health care is free does not help our Medicare beneficiaries. They are the ones who can least afford to suffer a decline in the quality of their health care. Indeed it may well be time for some of us to consider asking those Medicare benficiaries who can pay for their health care to begin contributing to its costs.

Nobody likes the idea of a "means test" for Medicare. Nevertheless, the interests of fairness require some beneficiary contribution, according to ability to pay, if an equitable solution to the deficit is to be found.

In summary, hospitals have responded to the new incentives of the Medicare prospective payment system. The goal of prospective payment was to reward efficient behavior by hospitals. Many hospitals have dramatically cut their costs and yet now they are being threatened with further payment cuts. Further reductions in payments for some hospitals will change the way they have traditionally delivered health care. It is clear hospitals will cut their costs again, but one must consider what quality and quantity of health care we want for Medicare patients. More importantly, a Medicare payment freeze will severely undermine a program that is working.

Mr. FROST. I will first have to ask you whether you prefer to be called Parker or Davis?

Ms. DAVIS. It doesn't matter. Pat Davis is fine.

Mr. FROST. OK. I want to make sure that we are addressing you correctly. Ms. Davis, your association of course, represents investor-owned hospitals?

Ms. DAVIS. Yes.

Mr. FROST. Could you tell us how, as a general rule, investor-owned hospitals have been faring under DRG's? Are your hospitals making money? Are they doing better than they were under the prior system? Worse? What is the general pattern?

Ms. DAVIS. I am not sure that I can speak for all of them, but I will say, certainly from the standpoint of the hospital that I am at right now, we have just finished, we have just now finished our first year under prospective payment and I don't have all the final numbers in, but I would say at this point, I dare say that we are probably going to do better than, a little better than we did last year. But we are going to do better than we did because, as I said earlier, we have taken some very stringent steps in order to manage and to control our expenses.

Mr. FROST. It is interesting, because the testimony that we have had has been to the effect, of course, that while there are a minority of hospitals that are losing money under the system, that by and large the great proportion of hospitals under this system are doing OK.

Ms. DAVIS. I think that goes back to, like you said before, there are lots of different factors from the standpoint of who loses money and who doesn't. I think the investor-owned hospitals you might expect to do a little bit better than the other hospitals, simply because I think they have always paid a great deal of attention to management, and a great deal of attention to expenses, and I think it was first.

Many of the nonprofit hospitals throughout the country and the public hospitals today throughout the country I feel have adapted many of the things that we have been doing over the past few years, and that particularly as it relates to staffing controls, and I think that any nonprofit or public hospital that you talk to would certainly share that piece of information with you also.

Mr. FROST. I wanted to ask you about some specific things in your testimony. You stated the administration and Congress should note that the Medicare hospital insurance trust fund does not contribute to the Federal deficit, of the projected dates for the insolvency for the Medicare trust fund is now beyond 1990, 8 years beyond last year's projection, primarily because hospital cost increases are dramatically lower than projected levels.

You later talk about a statement that you actually read to us, that if Congress and the executive branch impose a disproportionate share of the burden of budget cuts on hospitals it will represent a breach of faith on the part of the administration and of Congress. Do I understand your testimony to be, then, that the administration is looking to Medicare to help reduce the budget deficit, not because they need the money in the hospital trust fund, and that you feel this is a breach of faith?

Ms. Davis. No, no. I think the point I was trying to make is that the Medicare trust fund does not have anything to do with the dollars set aside when we talk about the budget deficit, but—and I certainly know that you are very concerned about regardless of whether it is a part of that or not, dollars are dollars. But what I am saying is the breach of trust that I speak of is the fact that you are talking about making changes in a program where we have barely been into the program for a little over a year, some hospitals 2 years, and what I am saying is what I feel so strongly about is you said do it with these dollars. We are trying our best to do it with those dollars. We have made some real cuts.

Now, you all know we can continue to cut, as I said before. There is no question about that. But the quality of care is going to be affected in the future. We have taken out supposedly those "inefficiencies," if I just lump that word, use the word "inefficiencies" and put that out there for all hospitals. But there is a point of no return, and that is my concern.

Mr. Frost. My question is should we, should the administration and Congress, be looking to Medicare to save money to try and improve the deficit situation when in fact the trust fund is now self-sufficient?

Ms. Davis. I don't think so, no.

Mr. Frost. It appears to us that the administration will come back next year and try and save some more money on the deficit out of Medicare.

Ms. Davis. I certainly have heard a couple of comments to that effect today, and like I said, that concerns me a great deal, because I think hospitals have already, as I said earlier, we have already accounted for 50 percent of the savings within Medicare, and we cannot continue, I don't feel, to provide a level of quality care.

I think technology is all a part of that, and I think you know if you just look at whether we call them new diseases or we just put names on them, but if you look at one thing that is happening, a current issue right now that we are trying to deal with in the health care field I think is AIDS. And though my hospital is not necessarily—at this point has it been affected like hospitals in some States where there appear to be greater numbers of AIDS patients than in others, but I can tell you that certainly in reading about how a hospital has to prepare themselves, there is no way of knowing from day to day how you are going to have to respond in different situations, or what is going to be the extent of today, so to speak.

But I guess I am saying that I think it is so important for you to realize that we have got to be capable of responding today to a problem.

I think we have already given as far as we can from the dollar standpoint.

Mr. Frost. You have some interesting recommendations I would like to ask you about. Page 10, you say that:

> Since the Federal income tax law subsidizes employer-purchased health insurance without limit, a tax-free fringe benefit which primarily helps the middle class, a cap on this benefit could provide new Federal revenues for an indigent care program.

Now, of course, the Ways and Means Committee is considering making some of those insurance premiums taxable to the employee, as a part of the overall tax simplification plan, and I assume that is what you are talking about?

Ms. **Davis.** Right; correct.

Mr. **Frost.** I would point out to you, though, that I believe the Ways and Means Committee has other plans for that money, as a part of tax reform, and I don't believe the Ways and Means Committee has in mind using that money for indigent health care.

Ms. **Davis.** Well, I appreciate your comments, and I would just like to say again to that, I think you know the most important point that I wanted to get across is that I think the uncompensated care problem is a problem that has got to be much more broad based than just looking at the disproportionate share issue, because I think the Federation of American Hospitals and myself right now personally, I am very much in support of a disproportionate share as a short-term alternative, but the important point I think, and the important issue, is that we have got a national problem here, and it is something that we all need to work on from the standpoint of finding a solution.

Mr. **Frost.** I just want to touch on several other of your recommendations near the end of your testimony, which relate to means tests for Medicare, which I think you would find to be a matter of some controversy in the Congress, of course. One, that you suggest that we could relate the Medicare part B premium to income by imposing a variable part B premium tied to income. You are not saying put a ceiling on it, but you are saying that if a person is in a high-income bracket, that their part B which goes to doctors' fees, that that premium would be higher than for everyone else?

Ms. **Davis.** Yes.

Mr. **Frost.** And second, tax Medicare benefits of beneficiaries—and I assume you are talking about the hospital benefits here?

Ms. **Davis.** Right.

Mr. **Frost.** Tax Medicare benefits of beneficaries with incomes in excess of $25,000, $32,000 per couple, similar to the recently enacted tax on Social Security benefits. Are either one or both of those proposals that you are making on behalf of the association that you represent, or are you making those? Are these proposals you are making as an individual?

Ms. **Davis.** They are proposals that I am making on behalf of the federation, but certainly that I am in support of as an individual.

Mr. **Frost.** Because both of these matters would be of some controversy.

Ms. **Davis.** I understand that. But I think out of controversy hopefully comes solutions.

Mr. **Frost.** And the other proposal that you made, to extend the current cigarette excise tax rate with part of the revenue earmarked for the Medicare hospital insurance trust fund.

Ms. **Davis.** Right.

Mr. **Frost.** Of course, that money may or may not wind up in the trust fund.

Ms. **Davis.** Yes.

Mr. **Frost.** The reconciliation legislation does take that back from 8 to 16. We lowered it to 8 but then we are bringing it back to

16. Are you talking about going beyond 16 cents a pack, or are you talking about just the difference between 8 and 16?

Ms. DAVIS. Just the difference.

Mr. FROST. We do have a vote, apparently. I really don't want to start. We have one more witness, Carter Melton. Let me find out about the vote. We probably will have to wait until after the vote to start his testimony. The committee will be in recess for approximately 15 minutes, at which time we will take Mr. Melton, and I will try and do that as quickly as possible. Mr. Melton is here, I assume.

We will be back in 15 minutes. Thank you for your indulgence.

[After recess.]

Mr. FROST. The hearing will resume.

Our final witness is T. Carter Melton, Rockingham Memorial Hospital, Harrisonburg, VA, representing the American Hospital Association.

Would you please proceed?

STATEMENT OF T. CARTER MELTON, PRESIDENT, ROCKINGHAM MEMORIAL HOSPITAL, HARRISONBURG, VA, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. MELTON. My name is Carter Melton, president of Rockingham Memorial Hospital, and we are a 330-bed not-for-profit hospital located in Harrisonburg, VA, in the middle of the central Shenandoah Valley, and we have been designated as a rural referral center.

Some of the issues I will be speaking of today are proposals that the American Hospital Association will be putting forward. We support those proposals even though they may work directly counter to the short-term best interests of our institution.

The American Hospital Association several years ago proposed the prospective pricing system as a means to moderate the health care hospitals for the Medicare Program. Hospital performance under this system indicates that the system is doing exactly what it was designed to do.

In 1984, total hospital expenses rose 4.5 percent, which represents the lowest rate of increase in the last 22 years, certainly much lower than the 10.2 percent in 1983 and the 15.8 percent increase in 1982.

There are some operational and utilization dynamics that accompany this price and cost information which are important to understand in order to get the entire picture.

In 1984, overall admissions to hospitals in this country dropped 4 percent from the previous year. They dropped one-half percent in 1983 from the previous year and in 1982 they leveled out.

Perhaps more significant to these hearings is the fact that the over 65 admission rate had been increasing steadily over the past decade, and turned around and dropped 2.9 percent in 1984.

The length of stay across the board was declining last year, by 3.6 percent last year, for those individuals that are under 65 and 7.6 percent for those individuals over 65. This was consistent with the long-range trend unfolding for several years.

In our particular hospital, the length of stay from 1983 through the midpoint of 1985 decreased 23 percent.

Full-time equivalents employed in the hospital field have been rising steadily during the early 1980's, up 3.5 percent in 1982, 1.5 percent in 1983. It also turned around in 1984 and declined by 2.3 percent.

In addition to the full-time equivalents, the number of beds actually staffed in an operation has also decreased.

I suppose the question is, what do these numbers tell us?

In the aggregate, they can tell us that generally the system that we have put in place is working, but there are also some problems that are beginning to emerge and some patterns which we think deserve serious consideration by this task force, by the entire Congress as it looks toward the future of the Medicare Program.

We are concerned about the equity issue pertaining to three specific areas. First of all, we think that there is an inequitable financial impact under this system which appears to be emerging by size and location of hospital.

For instance, it appears that rural hospitals may be hit much harder by this system than urban hospitals. Large hospitals seem to be more vulnerable than small hospitals, and that leaves large urban—or large rural hospitals, excuse me, the most vulnerable of all.

The second area of inequity has to do with inequitable payment and its impact by intensity of care that the institution delivers.

The Medicare DRG system is based around norms or averages, and those institutions such as the University of Pennsylvania and other teaching institutions that have been represented here today that treat a high proportion of very complex cases are suffering perhaps unduly under this system.

The third inequity that we see emerging that needs to be looked at has to do with the inequity created by large caseloads of uncompensated care where those hospitals that treat low-income Medicare patients appear to have higher costs than those hospitals which do not have a similar caseload.

We have presented to the Congress three broad recommendations to address these issues, and the first one is that a 1-year pause be implemented in the transition to a uniform national rate.

The second recommendation that we are making is that Congress give consideration to a DRG specific blending proposal which will be an interim solution as we search out and try to determine what exactly is a fair price for DRG's.

And along that line, I would like to mention that in the September issue of Business and Health magazine, there was an article by the people from Johns Hopkins which indicate that DRG's can only account for about 30 percent of the variability in hospital resource usage in this country, which means that somewhere in the system there is up to 60 to 70 percent that we can't put our hand on.

And finally, we are suggesting and recommending that an adjustment be considered for those hospitals which have a disproportionately high amount of indigent care and treat a disproportionately high number of low-income individuals.

Along this line, we are particularly concerned that any type of adjustment takes into account more than simply the Medicaid issue, because the low-income indigent care issue is much more broadly based than would be reflected in the Medicaid numbers.

Finally, my feeling is that what we have between the hospitals in this country and the Medicare Program is more than the relationship that would simply exist between a seller and purchaser of health care. We have a true partnership, and in that partnership we need some degree of predictability.

There are two elements that make it possible for a hospital to manage and either survive or go under in the prospective pricing system, and they are volume and prices.

We have no control over volume and the statistics are showing that our volume is making a radical shift away from inpatient care to more cost-efficient outpatient care.

We need to have a formula that will ensure hospitals how prices will be fixed in the future, and certainly we understand that you cannot predict exactly what the prices are going to be.

Over the last 3 years, $30 billion have been cut from the Medicare Program by legislative mandate and the current budget envisions $11 million more being cut in the future. The hospitals of America, by their performance and participation in the prospective payment system, wish to move forward with the Congress and with the Medicare beneficiaries to find an equitable and cost-efficient program.

What we do not want is to have the Medicare Program bear a disproportionate amount of budget and deficit cutting as the Congress considers the economic problems that face the Nation.

I shall certainly be happy to answer any questions that you may have.

[Testimony resumes on p. 229.]

[The prepared statement of Mr. Melton follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE HEALTH TASK FORCE
OF THE HOUSE BUDGET COMMITTEE
ON MEDICARE PROSPECTIVE PAYMENT ISSUES
October 7, 1985

SUMMARY

Prospective pricing represents a dramatic, and constructive, change in Medicare payment policies. The strong, positive responses of hospitals to incentives created by the new system demonstrate that economic incentives are more effective than regulatory controls in containing health costs. As a result, in 1984, hospital expenses rose 4.5 percent, the lowest rate of increase in 22 years, and Medicare expenditures increased at the lowest rate since the inception of the program. However, as hospitals gain more experience with the new system, they confirm the existence of problems that both were anticipated and unsuspected when the plan was designed. There are two main issues from which most of the system's problems stem: predictability of prices for Medicare services, and the equity of the pricing system.

INTRODUCTION

Mr. Chairman, I am Carter Melton, president of Rockingham Memorial Hospital, a 330-bed community hospital qualified as a rural referral center in Harrisonburg, Virginia. I am pleased to be here today to present the views of the American Hospital Association (AHA) on the impact of the prospective pricing system on hospitals.

The AHA originally proposed Medicare prospective pricing as the most effective means of moderating the rate of growth in Medicare outlays. The Reagan Administration and Congress agreed with that position, and adopted prospective pricing as the basis of payment for inpatient hospital services by Medicare.

Hospitals have responded positively to the new system's incentives, as well as to the incentives of new, competitively oriented financing systems in the private sector. As a result, in 1984, hospital expenses rose 4.5 percent, the lowest rate of increase in 22 years, and Medicare expenditures increased at the lowest rate since the inception of the program. Equity problems remain, but are solvable.

The idea underlying the prospective pricing system is that payment based upon prospectively determined prices creates incentives to keep costs below the prices and provides greater predictability for both hospitals and the Medicare program. Under the prospective pricing system, the hospital is at risk for the difference between costs and prices, as well as for fluctuations in volume. Because volume can change rapidly and unexpectedly, operating under a prospective pricing system is risky, but the risks are generally manageable. Because volume is unpredictable, predictable prices are important. Hospitals can plan and budget rationally, matching the services they offer to the needs of their communities, only if they can count on the revenues needed to support their services. While the exact schedule for prices that will hold over a period of years cannot be known, hospitals do need to know what the general level or trend in prices will be. Congress attempted to provide some certainty in the prospective pricing legislation by establishing a general formula: prices were to increase by a formula of "market basket plus one percent" during the first two years of the new system. In subsequent years, "market basket plus one percent" was to be a general baseline for the HHS Secretary to use in setting the prices.

Prices have not been predictable, however. Within six months of the implementation of prospective pricing, Congress changed the pricing formula from "marketbasket plus one percent" to "marketbasket plus one quarter of one percent." The Secretary, in setting prices for FY 1985, proposed to reduce prices by 3.4 percent, alledgedly to correct for inaccuracies in the data initially used by HHS to set prices. Eventually, HHS reduced prices by 1.05 percent. For the third prospective pricing year, the Administration has issued regulations freezing rates, and the Congressional budget resolution also assumes a freeze on rates. While some of the uncertainty created by these changes is appropriate, because a complex system inevitably will have a "shakedown period," much of it is not, because it results from alterations in policies intended to produce deficit reduction rather than to correct problems in the system.

Congress has legislated over $30 billion in Medicare cuts since 1981, and Medicare cuts of $11 billion are called for by the Congressional Budget Resolution for the next three years. Hospitals recognize the need to reduce the federal budget deficit, and are willing to contribute their fair share to the deficit-reduction effort. But the AHA believes it is harmful to providers and beneficiaries to continue down the path of making changes in the Medicare payment system solely for the purpose of reducing the deficit.

HOSPITAL PERFORMANCE

During calendar year 1984, total hospital expenses rose 4.5 percent, less than one-third of the rate of increase two years ago (15.8 percent) and less than one-half of the 1983 rate (10.2). Inpatient expenses in 1984 increased only 3.2 percent. The dramatic slowing of the rate of increase in costs is largely the result of three factors. First, admissions have declined sharply for both the over-65 and under-65 populations. Total admissions declined 4.0 percent in 1984, after experiencing no change in 1982 and declining .5 percent in 1983. Admissions of patients under 65 declined the most sharply in 1984: 4.5 percent. The change in admissions of patients over 65 was also dramatic. After rising steadily for more than a decade, the over-65 admissions declined 2.9 percent in 1984.

The second factor contributing to the slower increase in hospital expenses in 1984 was a continued decline in average length of stay. Lengths of stay have been declining for many years, with a recent acceleration in the decline. In 1984, the length of stay of patients under the age of 65 was 3.6 percent lower than the previous year. The length of stay of patients over the age of 65 declined 7.6 percent between 1983 and 1984. The combined effect of shorter stays and fewer admissions has been a sharp reduction in hospital inpatient census.

The third major factor responsible for slower expense growth is a reduction in hospital employment made possible both by lower census and staffing efficiency improvements. Total full-time equivalent employees increased at rates of 3.7 and 1.4 percent in 1982 and 1983, respectively. In 1984, full-time equivalent employment declined 2.3 percent. Because admissions and length of stay declined, the number of staff hours per admission continued to rise, but at a lower rate of increase, 0.5 percent in 1984 compared to 3.4 percent in 1982 and 1.4 percent in 1983. This lower rate of growth is remarkable considering that the admissions which have been eliminated are probably lower-intensity cases.

Due largely to the slower growth of expenses, hospital patient-service operating margins increased modestly from 1.0 percent in 1983 to 2.0 percent in 1984. While no one has reliable data on operating margins for Medicare and other payers, with one category separated from the other, anecdotal evidence suggests that Medicare has contributed to some extent to the improved financial picture. Anecdotal evidence also strongly suggests that the increase is extremely uneven. About half of the nation's hospitals have completed their first year under prospective pricing, and many of these hospitals are still in the process of reconciling their accounts and preparing their annual financial statements. HHS has just recently issued cost report forms for the first prospective pricing year; consequently, few hospitals know with any degree of certainty whether the implementation of prospective pricing has resulted in a net gain or a net loss. Even fewer hospitals would be able to identify the reasons for any gain or loss without more time for analysis.

EQUITY ISSUES

Hospitals' experience during the first fiscal year under prospective pricing is of limited value in anticipating the impact on institutions once the system is fully implemented. However, the AHA has examined intensively the data that are currently available--basically the data used to establish prospective prices during the first and second years. Although these data admittedly are not as current as would be desirable, they do indicate the general pattern of impact that will occur.

The transition to uniform prices based on average cost-per-case in urban and rural areas highlights the defects of the DRG system, as well as the limitations of the current price-setting method. The AHA analysis has identified several significant patterns, some of which were expected. One finding is that hospitals treating a complex mix of patients are more likely to experience losses of revenue than hospitals providing services for a less complex mix of patients. This finding implies that payments for DRGs with above-average prices do not, in general, cover the costs of the services needed by patients in those DRGs.

Another finding is that large hospitals are more likely to experience significant losses of revenue--compared to the revenues they would have received under cost-based reimbursement--than are small hospitals. This is particularly true in rural areas. It seems that many of the largest rural hospitals, despite the doubling of the "indirect education factor," are more likely than non-teaching hospitals to experience losses of revenue.

An additional finding is that small, rural hospitals are more likely to experience either a substantial gain or a substantial loss than are larger rural hospitals. The reason for this polarization are unknown, suggesting a need for further research into the effects of prospective pricing on rural hospitals. This need is reinforced by the recent substantial decline in the number of admissions and inpatient census of rural hospitals, a decline that has caused a significant deterioration in the financial position of many rural institutions.

Although individual hospitals have experienced problems, these problems generally have been limited to the specific circumstances of each hospital, with most system-wide problems difficult to detect. As hospitals move through the second year and into the third year of prospective pricing, system-wide problems are expected to become more apparent.

The transition to uniform prices is expected to exacerbate existing problems, leading to disproportionate losses of revenue for hospitals that are struggling under the system, particularly those with complex case mixes. A pause in the transition to national prices, as called for in the House Ways and Means Committee's reconciliation legislation, would allow time for assessing the impact of the current system and fine-tuning it to mitigate the problems that we have identified.

DRG-SPECIFIC PRICE BLENDING

As transitional issues are being addressed, DRG-specific blending of hospital-specific and national-average prices has been proposed by the AHA as a more equitable, interim method for establishing DRG prices than the present three-year transition to fully national rates. Price blending would be budget-neutral in relationship to the current price-setting approach.

Under the fully implemented prospective pricing system, the range of gains and losses would be wide. For example, at the national level, an estimated 16 percent of hospitals would experience Medicare financial losses of 20 percent or more; approximately 34 percent would experience losses of 10 percent or more. In contrast, under a DRG-specific price blending system, the depth of gains and losses would narrow considerably. For example, at the national level, the proportion of hospitals in the "20 percent or more" loss category would drop from 16 percent under national rates to less than 1 percent under DRG-specific price blending. The 1984 Congressional Budget Office DRG-specific price blending study shows the same basic pattern of less extreme losses and gains relative to the fully prospective pricing system.

Under price blending, each DRG's price would be a 100-percent national average rate, a 100-percent institution-specific rate, or a percentage blending of the two. The percentage blend would be based on an analysis of how widely or narrowly Medicare patients' costs per case for a given DRG are distributed around the DRG's national average cost. Where the distribution would be narrow for a DRG, the DRG price would be set at or near the national average rate. Conversely, if the distribution were wide, the price would be heavily weighted toward the hospital-specific rate. This is not a theoretical, untried concept. The New Jersey DRG-rate setting system has used price blending from its inception to avoid inequities.

DISPROPORTIONATE SHARE ADJUSTMENT

Another equity issue that has received considerable attention from both Congress and hospitals is the need for a disproportionate share adjustment for hospitals treating a large number of low-income patients. The need for such an adjustment is well documented, and has been recommended by the Prospective Payment Assessment Commission. The purpose of such an adjustment would be to recognize that hospitals caring for a disproportionately large number of low-income patients tend to have a Medicare cost-per-case higher than the national average. The reasons for this relationship remain unclear, but may be related to differences in the average severity of illness experienced by Medicare patients treated in these hospitals, the systematic bias against high-cost DRGs created by the current method of setting prices, or the problems that have been experienced with the area wage adjustment. Whatever the reasons, the effect of moving to national rates is to penalize these hospitals, further adding to the financial stress associated with a substantial volume of uncompensated care.

The AHA recommends that Congress mandate an adjustment in 1986 DRG prices for hospitals serving a disproportionately large number of low-income patients. The adjustment should avoid low-income measures that essentially are Medicaid-only and therefore fail to capture the full extent of medical resources committed to low-income patient care. A "Medicaid plus uncompensated care" measure would be the most practical, sensitive approach for the time being. Rural hospitals should be covered by the adjustment with special provisions to recognize the differences between rural and urban settings.

CONCLUSION

I appreciate this opportunity to present AHA's views on prospective pricing issues. The hospital industry is in partnership with the Medicare system to provide high quality health care, a partnership deepened with the establishment of the prospective pricing system. To be successful in a competitive and rapidly changing environment, hospitals must have reasonable certainty about the payment policies of the Medicare system. Basing decisions about that system on program and policy assumptions rather than budget concerns will go a long way toward assuring the system's smooth functioning. In addition, the equity problems of the present pricing formulas can be corrected by a pause in the transition to national prices, implementation of DRG-specific price blending, and implementation of a disproportionate share adjustment.

Mr. **Frost**. I find your testimony very concise and very much to the point.

I would ask you if you could be more specific on the question of the DRG's specific price blending. I have read your statement, but I am not sure I understand which one of the options would be chosen for each hospital.

Would that be up to the hospital or someone else to make that decision?

Mr. **Melton**. A formula would be devised, a predetermined formula, and where there are large swings in the resource consumption and the cost of specific DRG's, the closer the cluster of prices to the national norm, the more that scale would rely on the national average per DRG payment, and where there is a large disparity, you would have a blending between the hospital specific cost and the national price.

Mr. **Frost**. You do favor the 1-year pause?

Mr. **Melton**. Yes; we need to. There are other reasons besides the pricing mechanism.

Mr. **Frost**. I did find your statements on page 3 interesting, talking about some recent changes the administration made, and while some of the uncertainty is appropriate, because a complex system will have a shakedown period, much of it is not because it results in alterations and policies intended to produce deficit reduction rather than correct problems in the system.

I assume that you are talking about programs that are part of the hospital insurance trust fund which is self-sustaining, and yet the administration has chosen to make cuts to show some deficit reductions even though they are not needed in this current year because of the status of the trust fund.

Mr. **Melton**. That is correct. From the institutional level, it is extremely difficult to plan the outyears of programs and services that we want to offer if the ground rules keep changing from under us.

Mr. **Frost**. I appreciate your patience and your excellent statement. Thank you for appearing today.

Mr. **Melton**. Thank you.

Mr. **Frost**. That concludes the hearing for today. This series of hearings will resume 2 weeks from today on Monday, October 21 in this hearing room at 1 o'clock.

[Whereupon, at 3:50 o'clock, the task force adjourned until Monday, October 21, 1985.]

MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

MONDAY, OCTOBER 21, 1985

House of Representatives,
Task Force on Health,
Committee on the Budget,
Washington, DC.

The task force met, pursuant to notice, at 1:05 o'clock, in room 210, Cannon House Office Building, Hon. Martin Frost (chairman of the task force) presiding.

Mr. Frost. Good afternoon, and welcome to this public hearing of the House Budget Committee Task Force on Health. This is the third and final hearing on the Medicare Program and the prospective payment system.

We are examining the Medicare Program because we believe that Congress needs to have a full understanding of the effect of recent program changes before entertaining additional changes that will likely be requested by the administration when it submits its budget for fiscal year 1987. It is the purpose of these hearings to help in this education process so that informed budget decisions on Medicare can be made.

In the first two sessions, we heard from several witnesses on the impact of the prospective payment system on hospitals and on the financial health of the hospital trust fund. Today, we will be looking at the impact of this reimbursement method on the quality of care provided to Medicare beneficiaries.

Since the beginning of its implementation in 1983, some concern has been expressed that the prospective payment system has actually led to a decline in the quality of care given to our Nation's elderly. Critics of the system frequently point to changes in hospital admission and discharge policies as examples of declining care under Medicare.

Many of today's witnesses work with Medicare patients, especially in the post-hospital setting. We have asked them to comment on whether they have detected any change in the quality of care provided to Medicare beneficiaries during the last few years. We have also asked for any suggestions they might have for improvements in the system.

We will hear first today from Hon. Claude Pepper, chairman of the House Rules Committee and member of the House Select Committee on Aging. We will then hear from Russell Heeren of the American Association of Retired Persons. Dr. William Felts is here to represent the American Medical Association, and he will be followed by Alan Spielman, representing Blue Cross and Blue Shield Association. We will conclude today's hearing with a panel whose members will include Paul Willging of the American Health Care Association; Mary Fisher of the American Nurses Association; and Margaret Cushman of the National Association for Home Care.

Donald Reilly was unable to be with us today. I am delighted all of you could be here and I am looking forward to hearing your testimony. I am particularly pleased to have Senator Pepper with us today who, of course, chairs the Rules Committee that I serve on. It is a pleasure to work with Congressman Pepper, and I look forward to hearing your testimony today and I know it will be very helpful to this committee.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. **Pepper**. Thank you very much, Mr. Chairman, members of your distinguished committee.

I warmly thank the distinguished chairman and his colleagues on the task force for the leadership you are giving the field of health care for all Americans and especially older Americans who need so desperately the thoughtful leadership and help you can give them. I am extremely pleased that this task force has convened a series of hearings to examine the impact of changes in health care policy and financing of the American public.

As you know, over 2 years ago, in an effort to reduce spiraling health care costs, Congress established a new system for paying for hospital care provided to Medicare beneficiaries. This new prospective payment or DRG system has had a profound impact on this Nation's health care system. Perhaps most importantly, it has served to magnify and focus attention on a number of shortcomings of our entire health care system. It is forcing us to look with greater scrutiny at these problems and to search out new solutions for the future. Let me be both general and specific.

Never before have we been forced to examine so closely changes in the care being provided in our Nation's hospitals. Under the new Medicare Prospective Payment System, the average length of stay in the hospital has dropped from 9.5 to 7.5 days in only 1 year. Part of this decline is the result of increased efficiency, part has come at the expense of quality of care.

I will say, Mr. Chairman, that just about the time this proposal came out I happened to be giving a talk at Harvard Medical School in Cambridge, and I had lunch with the dean and some of the professors of the school, and the dean ventured to speak out. He said:

> I just cannot understand how it is reasonable to expect the hospital to charge the same amount for an old man that comes into the hospital with a bad case of pneumonia and a young man who comes into the hospital with a light case of pneumonia and yet under the rules they are supposed to charge the same thing. They both have pneumonia, but different ways of suffering from a given disease.

Recent reports by the General Accounting Office, the National Association of Area Agencies on Aging, and the American Society of Internal Medicine have found that hospitals are discharging patients "quicker and sicker" and are denying care to many who would be "bad debts" because of their age or severity of illness. I have received literally hundreds of letters from across the Nation, telling of individual cases of quality care being scrapped in the name of cost containment and of sick elderly people with nowhere to turn.

Never before have we been forced to look so carefully at the care provided our Nation's 1.5 million nursing home residents. We found that as a result of this new DRG system, nursing homes are having to care for older, sicker and more dependent people. Yet, partly because of cutbacks of over $3 billion in the Medicaid Program and billions more in Medicare, they are providing less and less skilled care. In 1984, residents of skilled nursing facilities received only about 1 hour and 43 minutes of direct care. Of this, less than one-half of an hour of care is provided by nurses, less than half a minute of direct care daily is provided by doctors. The balance is provided by unlicensed nurse aides who are typically undertrained, underpaid and grossly overworked.

We have had many instances where fine young ladies were allowing people to suffer who were being treated by them because they did not know the significance. One young lady like that who was not trained, was moving her patient and she noticed that he went through terrible grimaces of pain every time she moved him. She found out later that he had cancer of the bone and every time she moved him his bones were breaking. Well, the poor lady did not do it intentionally; she just was not adquately trained.

Our subcommittee found that abuse and neglect of nursing home residents is a growing nationwide problem as a result of these cutbacks. Imagine our shock when last month a man from Texas told our subcommittee that his father died of a gangrene infested bed sore which had developed and worsened due to neglect on the part of the nursing home at which he stayed.

My wife was in the hospital for a year and a half off and on, and she had a bed sore. It was nothing but poor care that was responsible for those bed sores, they tell me.

Right here in Washington a frail woman was placed in a tub of scalding water and never checked on, even though she screamed and suffered severe burns. After being removed from the tub, the woman was wrapped in sheets to conceal the burns and was never given treatment. She later died from the burns. Sadly, these cases are not isolated ones. Our subcommittee found that one in seven nursing home residents may be the victims of abuse or neglect each year.

Never before have the inadequacies of our Nation's noninstitutional long-term care system been made so glaringly evident.

The DRG system has also resulted in people being sent from hospitals to their own homes sicker and more dependent. Because of this, the need for home and community based services has increased dramatically. Demand for case management services has increased nearly fourfold since the imposition of the DRG system. Demand for in-home skilled nursing care has increased nearly 200 percent, housekeeping services 70 percent and in-home personal care over 60 percent. Yet, services have been cut by this administration.

Mr. Chairman, may I suggest that you look into one thing we seem to have been hesitant to undertake in this country. I understand in Britain people of a family can be employed to look after patients who stay at home. Our committee was holding a hearing in Miami one time and we had a lady witness who said she was about 35 to 40 years old, living with her mother in a home that they owned. She said, "My mother is going to a nursing home next week unless I can stay at home and look after her." She said, "I am a waitress by profession and I make about $5,000 or $6,000 a year." But she said, "If I can make $250 a month, I could stay home with my mother. We own our home. That would give us enough to live on and my mother would not have to go to an expensive nursing home."

Now, why cannot we adopt a simple thing like that? I am not talking about a rich family where it is the duty of the children to look after their family. I am talking about somebody who has to give up a job, who is the breadwinner of the family and it is obvious that it is a bona fide case. It would save a lot of money and provide much better for the individual involved.

The Medicaid home and community based waiver program allows States to keep elderly in their homes and out of nursing homes. This program has proven a godsend to thousands of seniors and saved over $400 million in nursing home costs during its first year. The administration, however, has done its best to prevent this "bad idea" from helping more elderly.

Perhaps nowhere is the inadequacy of our current system so grossly displayed as in the care available to the up to 4 million victims of Alzheimer's disease in this Nation. There is no DRG for Alzheimer's disease. In fact, Medicare does nothing for these people. What we do have is a system which lends truth to the sad statement of the daughter of an Alzheimer's patient. This woman recently told our subcommittee, "My doctor told me that the only way to get assured financial assistance for my mother would be to break her arm. When her arm heals, break it again, and keep breaking it if you want to get some financial assistance."

Mr. FROST. If I could ask at this point, is the reason for that, that Alzheimer's patients generally stay at home, that they are not hospitalized, and is that the reason?

Mr. PEPPER. No; the system is not now adapted—there is a limited time of stay provided in the hospital and Medicare is designed for people who have a serious illness, relatively short in nature, where there is prospect of improvement that will get them back on their feet again. In other words, if they are sicker, they can get in the hospital to get well, but if they are long-term care patients as are those with Alzheimer's disease—who gets worse and more helpless as times goes on—there is no coverage.

Never before have there been such perverse incentives in our payments for health care.

Our subcommittee found that efforts to cut costs by shifting surgery from the hospital to less expensive settings has been an unmitigated disaster. Much surgery has been moved from the hospital, but at even greater cost. For example, while Medicare pays no less than $2,400 for cataract surgery performed on an inpatient hospital basis, when the same surgery is performed at the same hospital, even by the same doctor, but on an outpatient basis, Medicare is paying up to several times this amount—as much as $5,700—for using only 3 hours of hospital resources. Because of this nonsensical policy, Medicare will waste as much as $1.2 billion this year.

Now, Mr. Chairman, remember, this little orb of a lens that they put in the back of the eyeball in the place of a natural little lens that is there, costs $60, $50 or $60 by the manufacturer, and yet even now under our cost containment the hospital and the doctor takes usually about 30 minutes for the doctor to perform this operation. It is a wonderful new technique and wonderful new discovery, but they surely make a good profit on it. They charge $2,400 now altogether for the $60 that little thing costs and 30 minutes for the doctor to put it in and an hour or two time of the hospital. What we are suggesting—we suggested it to the Ways and Means Committees—is that if they would make the outpatient service subject to the same limitation as the inpatient, they would save about $1 billion a year in cost to Medicare and impair in no way the services performed to the recipient of this beautiful service.

Never before has there been a greater need to seek out and eliminate fraud and abuse in the Medicare and Medicaid Programs.

This administration has not seemed to hesitate in cutting our desperately needed health care services. Sadly, it has not shown the same enthusiasm for cutting out widescale fraud and abuse before making these cuts.

Our subcommittee found that in just this one area, cataract surgery, Medicaid and Medicare could save as much as $700 million this year simply by eliminating fraud and abuse. We found instances in our testimony from distinguished doctors that operate in this area that some doctors in order to make the money would, for example, encourage truckdrivers to come and get a new one of these inserts, although they had 20-20 vision. They told them you could see better at night if you let us put one of these artificial things in. How can they improve on perfect vision very much? But they can sell a truckdriver, well, maybe he can see a little better at night if you got one of these transplants.

We found that doctors and hospitals are receiving a whole range of inducements—from free cars and vacation homes to cash deposits in bank accounts in the Grand Cayman Islands—all at the expense of Medicare and the American taxpayer.

We had some outstanding doctors in this field come and say they were ashamed that some of the members of their own profession were dishonoring their profession by taking these benefits and doing things that were not ethical.

Clearly, we all face a very difficult challenge. We must assure that all Americans, regardless of age or income, receive the quality health care they deserve, while at the same time working to reduce spiraling health care costs. It is a challenge which the American public, especially elderly Americans, cannot afford to have unmet.

What can be done? I have introduced legislation which might be thought of as a starting point. These include:

One, H.R. 524, which I introduced with Senator Gore from Tennessee, would establish 20 regional treatment and research centers for Alzheimer's disease. These centers would focus on how best to care for Alzheimer's patients outside of costly nursing homes.

Another, H.R. 3091, would make more sensible Medicare payments for cataract surgery and eliminate much fraud and waste. This bill would save as much as $4 billion over the next 3 years.

Another, H.R. 523, calls for the establishment of a bipartisan blue ribbon commission on Medicare. This commission would review Medicare benefit and payment structure and methods that encourage and reward efficient provision of services, and make recommendations about how best Medicare can provide for the needs of our Nation's elderly in both the long and short term.

Mr. Chairman, let me just say this by way of general summary.

The announcement appeared in the paper recently that the new deductible the administration was bringing out the latter part of the year would raise the amount that a Medicare patient had to pay who entered a hospital from $400 to $492. Now, that is $500 and there are lots of elderly people who get sick and need to go to a hospital who do not have $500 in the bank or under the pillow to take and give to the hospital so they can get into the hospital. Furthermore, Mr. Chairman, our committee has found out that when we established Medicare in 1965, 20 percent of the personal income of elderly people was being employed for their medical care. Today the same percentage is being expended.

In other words, we have got Medicare, but the elderly are paying the same percentage of their own income for their medical care that they were paying in 1965 when we started.

Yet Medicare does not cover Alzheimer's disease. It does not cover long-term care. Look at the people who are helpless invalids who need some place of refuge, some place of custody or abode, where they will have a little tender care to spend the last of their days on earth. Medicare does not provide that nor does any other system that we have now to speak of.

The next thing is eyeglasses and hearing aids. Essentially all of us nearly wear eyeglasses after we get over 40 years of age. Many of us wear hearing aids, without which we would be very much impaired, very much embarrassed. The elderly if they do not have the money—these things cost around $500 or $600—have to go along not hearing what is going on, embarrassed, isolated because they are not covered.

A lot of people need foot care which is not provided under Medicare. Furthermore, the other day a lady sat at my desk here in my office and she said, "Mr. Pepper, if you will look at my eyeballs you will see they have already turned yellow, indicating that I have got a liver disease, and the doctors tell me that if I do not have a transplant within 6 or 9 months I will be dead in 12 months." She said, "I have got $45,000 that I have been able to raise from generous people, but they tell me it will take $150,000 to get me on the waiting list in the hospital and another $50,000 before it is over."

Later I called the lady in your city of Houston where she lives now, used to live in Miami. She said, "Well, I am a little more cheerful, Mr. Pepper." She said, "I have raised some more money. I found a hospital over in Tennessee that will do the operation a little cheaper, and all I need now is $50,000. If I can get $50,000, I can live."

Well, I should not go into it, but I called the head of the biggest radio station in Houston, got that man on the phone, and he promised me he would raise the $50,000. That is just one case. There are thousands of Americans who need heart transplants and liver transplants and other things which are the only chance they have to live, and we do not offer them any hope or help very much.

Furthermore, I think of these young people starting out in life. They will be starting their family, getting their business going, doing their jobs. They do not know that some of these days out there they might have Alzheimer's disease, they might have to have a transplant or something. I would like for us to offer them some way that they could start paying in when they start to work, paying into an insurance company, paying into somebody.

What I am coming to is this, Mr. Chairman. The other day I talked to a man who used to be president of the University of Alabama. I saw him over in the dining room. He said he is now with Kettering. I said, listen, I am looking for somebody that is trying to put together an American medical system where everybody will pay what they can and should and everybody in America, man, woman and child get the medical care they should have and I want somebody to help put that together.

Well, he said, the Ford Foundation is working on it right now. So I am going to get in touch with them. I had a meeting in my office on the first of May. I had six of the biggest insurance companies, the head of the American Medical Association, Hospital Association and the like. The insurance companies are beginning to be more liberal in their approach. They want to be more helpful. What we need now is some strong, able, aggressive leadership that will pull this thing together, a great American plan. I am not talking about socialism or anything else. I am talking about Americanism that will do what America likes to do, help those who need help after they have done their share to help themselves.

So it may be your committee, Mr. Chairman. I know by your good offices and your personal encouragements and assistance much can be done in reaching toward the realization of that great dream to give medical care to everybody who needs it in America.

Thank you very much.

[The prepared statement of Mr. Pepper follows:]

Prepared Statement of Hon. Claude Pepper

Mr. Chairman, members of the committee, I warmly thank the distinguished chairman and his colleagues on the committee for the leadership you are giving the field on health care for all Americans, an especially older Americans who need so desperately the thoughtful leadership and help you can give them. I am extremely pleased that this committee has convened a series of hearings to examine the impact of changes in health care policy and financing on the American public.

As you know, over two years ago, in an effort to reduce spiraling health care costs, Congress established a new system for paying for hospital care provided to Medicare beneficiaries. This new prospective payment or "DRG" system has had a profound impact on this nation's health care system. Perhaps most importantly, it has served to magnify and focus attention on a number of shortcomings of our entire health care system. It is forcing us to look with greater scrutiny at these problems and to search out new solutions for the future. Let me be both general and specific.

Never before have we been forced to examine so closely changes in the care being provided in our nation's hospitals.

Under the new Medicare prospective payment system, the average length of stay in the hospital has dropped from 9.5 to 7.5 days in only one year. Part of this decline is the result of increased efficiency, part has come at the expense of quality of care.

Recent reports by the General Accounting Office, the National Association of Area Agencies on Aging and the American Society of Internal Medicine have found that hospitals are discharging patients "quicker and sicker" and are denying care to many who would be "bad debts" because of their age or severity of illness. I have received literally hundreds of letters from across the nation, telling of individual cases of quality care being scrapped in the name of cost containment and of sick elderly people with nowhere to turn.

Never before have we been forced to look so carefully at the care provided our nation's 1.5 million nursing home residents.

We found that as a result of the new "DRG" system, nuring homes are having to care for older, sicker and more dependent people. Yet, partly because of cutbacks of over $3 billion in the Medicaid Program and billions more in Medicare, they are providing less and less skilled care. In 1984, residents of skilled nursing facilities received only about 1 hour and 43 minutes of direct care. Of this, less than one 1-half of an hour of care is provided by nurses, less than half a minute of direct care daily is provided by doctors. The balance is provided by unlicensed nurse aides who are typically undertrained, underpaid and grossly overworked.

Our subcommittee found that abuse and neglect of nursing home residents is a growing nationwide problem as a result of these cutbacks. Imagine our shock when last month a man from Texas told our subcommittee that his father had died of a gangrene infested bed sore which had developed and worsened due to neglect on the part of the nursing home at which he stayed. Right here in Washington a frail woman was placed in a tub of scalding water and never checked on, even though she screamed and suffered severe burns. After being removed from the tub, the woman ws wrapped in sheets to conceal the burns and was never given treatment. She later died from the burns. Sadly, these cases are not isolated ones. Our subcommittee found that one in seven nursing home residents may be the victims of abuse or neglect each year.

Never before have the inadequacies of our nation's non-institutional long-term care system been made so glaringly evident.

The "DRG" system has also resulted in people being sent from hospitals to their own homes sicker and more dependent. Because of this, there the need for home and community based services has increased dramatically. Demand for case management services has increased nearly fourfold since the imposition of the DRG system. Demand for in-home skilled nursing care has increased nearly 200 percent, housekeeping services 70 percent and in-home personal care over 60 percent. Yet, services have been cut by this administration.

The Medicaid Home and Community-Based Waiver Program allows States to keep elderly in their homes and out of nursing homes. This program has proven a godsend to thousands of seniors and saved over $400 million in nursing home costs during its first year. The administration, however, has done its best to prevent this "bad idea" from helping more elderly.

Perhaps nowhere is the inadequacy of our current system so grossly displayed as in the care available to the up to 4 million victims of Alzheimer's disease in this nation. There is no "DRG" for Alzheimer's disease. In fact, Medicare does nothing for these people. What we do have is a system which lends truth to the sad statement of the daughter of an Alzheimer's patient. This woman recently told our subcommittee, "My doctor told me that the only way to get assured financial assistance for my mother would be to break her arm. When her arm heals, break it again, and keep breaking it, if you want to get some financial assistance."

Never before have there been such perverse incentives in our payments for health care.

Our subcommittee found that efforts to cut costs by shifting surgery from the hospital to less-expensive settings has been an unmitigated disaster. Much surgery has been moved from the hospital, but at even greater cost.

For example, while Medicare pays no less than $2,400 for cataract surgery performed on an inpatient hospital basis, when the same surgery is performed at the same hospital, even by the same doctor, but on an outpatient basis, Medicare is paying up to several times this amount—as much as $5,700—for using only 3 hours of hospital resources. Because of this nonsensical policy, Medicare will waste as much as $1.2 billion this year.

Never before has there been a greater need to seek out and eliminate fraud and abuse in the Medicare and Medicaid programs.

This administration has not seemed to hesitate in cutting out desperately needed health care services. Sadly, it has not shown the same enthusiasm for cutting out widescale fraud and abuse before making these cuts.

Our subcommittee found that in just one area, cataract surgery, Medicaid and Medicare could save much as $700 million this year simply by eliminating fraud and abuse. We found that Medicare is paying up to $700 for the little plastic lens implanted in the eye during cataract surgery. This lens costs about $35 to make.

We found that doctors and hospitals are receiving a whole range of inducements—from free cars and vacation homes to cash deposits in bank accounts in the Grand Cayman Islands—all at the expense of Medicare and the American taxpayer.

Clearly, we all face a very difficult challenge. We must assure that all Americans, regardless of age or income, receive the quality health care they deserve, while at the same time working to reduce spiraling health care costs. It is a challenge which the American public, especially elderly Americans, cannot afford to have unmet.

What can be done? I have introduced legislation which might be thought of as a starting point. These include:

One, H.R. 524, would establish 20 regional treatment and research centers for Alzheimers' disease. These centers would focus on how best to care for Alzheimers' patients outside of costly nursing homes.

Another, H.R. 3091, would make more sensible Medicare payments for cataract surgery and eliminate much fraud and waste. This bill would save as much as $4 billion over the next 3 years.

Another, H.R. 523, calls for the establishment of a bipartisan blue-ribbon Commission on Medicare. This Commission would review Medicare benefit and payment structure and methods that encourage and reward efficient provision of services, and make recommendations about how best Medicare can provide for the needs of our nation's elderly in both the long and short term.

There must be major change. I believe that we must begin to look beyond the acute and institutional biases of our current health care system to the availability of preventative and community care. It is imperative that with any new major reforms this committee and this Congress might review, consideration be given to the means not only to protect the integrity and fiscal solvency of our health care system now and tomorrow, but also how to provide the means by which services so desperately lacking might be made available.

Mr. **Frost**. Senator, thank you for your excellent statement, your longstanding interest and your commitment to the concerns of the senior citizens is well known. I can personally attest to your energy in the pursuit of those concerns and, as I said at the beginning, I enjoy serving with you very much on the Rules Committee. I know that you have many interests and that this is very high on your priority list and always has been, and the senior citizens of our country are indeed fortunate to have you as their champion.

Mr. **Pepper**. I am proud to work with you, Mr. Chairman.

Mr. **Frost**. Thank you very much.

Mr. **Pepper**. Thank you.

Mr. **Frost**. The next witness is Russell Heeren, representing the American Association of Retired Persons. If you will proceed.

STATEMENT OF RUSSELL HEEREN, MEMBER, NATIONAL LEGISLATIVE COUNCIL, ON BEHALF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY JACK CHRISTIE, LEGISLATIVE STAFF

Mr. **Heeren**. Good afternoon, Mr. Chairman.

My name is Russell Heeren, and I am a member of the National Legislative Council of the American Association of Retired Persons. With me is Jack Christie of our legislative staff.

On behalf of the 20 million members of the AARP, I want to thank you for this opportunity to state the association's views on the Medicare DRG prospective payment system and its impact on the quality of health care. After having made substantial changes to the cost side of the Medicare health care equation over the last 2 years, it is appropriate that we pause in order to assess what is happening to patients and the quality of their care. Increasingly, the question we at AARP and others are asking is, Are we delivering health care for less, or are we just delivering less health care?

My testimony today identifies two areas of concern about the implementation and operation of the DRG system so far. One, the Health Care Financing Administration's [HCFA] failure to adequately monitor and correct for the economic incentives under DRG's to underserve patients, and two, the serious lack of policy coordination and support of DRG's by contemporaneous HCFA policies. A third point we will make today is our concern about recent proposals to achieve deficit reduction and the likely impact on quality of care. Although we have additional concerns, most particularly the seeming lack of due process for the beneficiary faced with a noncoverage decision, we will focus this testimony on the need for a commitment to check the system's inherent incentives to skimp on services.

Following the brief discussion of these points, AARP makes several recommendations to improve the administration of DRG's.

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old "cost-plus" system, hospitals were paid for each service provided. The more services provided, the more money the hospitals received. Thus, it was in the hospital's interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRG's however, those incentives are gone.

Under DRG's, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon a possible in order to maximize their profit. Moreover, new administrative rules and policies under DRG's limit Medicare patients' utilization of certain kinds of care and medical procedures. The incentives inherent in the DRG system, combined with the new rules implementing it, substantially alter Medicare patients' rights.

This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways. One, there is greater jeopardy to individual health status from skimping on services, and two, there is greater financial liability for services now deemed to be noncovered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required. Evidence is mounting to demonstrate that patients are indeed sustaining harm under the implementation of this policy.

In February 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRG's. Witnesses testified about the problems of early discharge and lack of post acute care services.

On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting Office on the impact of Medicare's new prospective payment system on posthospital care. The report showed that Medicare patients run a substantially greater risk of being discharged "quicker and sicker," too often with no place to go.

In July, Senator Heinz, chairman of the Senate Aging Committee, announced that PRO's had uncovered some 3,700 instances of inappropriate release or transfer of elderly hospital patients as of March 1985. Although the actual number of such cases has been challenged by HCFA, the point to remember is that the PRO's are not uniformly making assessments on transfers and readmissions. The PRO's that are committed to this task have reported over 4,500 cases to HCFA regional offices as possible inappropriate discharges as of October 1983 through May 1985.

The American Association of Retired Persons is also trying to evaluate the scope and breadth of the problems affecting patient care under DRG's. The association has received over 300 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers, complaining about poor care and premature discharge under DRG's.

A related development reported by some nursing home ombudsmen is that, as patients are referred to nursing homes with acute care needs, they are "bumping" older persons with chronic disabilities from the waiting lists, exacerbating the difficulty of gaining access to scarce nursing home beds for many who are eligible but perceived as less vulnerable. At the same time, many nursing homes find themselves ill-equipped to provide appropriate care for these more vulnerable patients.

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRG's on discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post acute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities [SNF] have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNF's to become involved in Medicare, Congress provided a mechanism for cushioning SNF's against wrong decisions about whether a patient is covered for SNF care. This cushion is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent 5 percent or less of the provider's Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a proposed rule earlier this year, HCFA eliminated the waiver of liability by eliminating the presumption of good faith. The result of this change would be to further discourage SNF's from taking Medicare patients, thus making it even more difficult for post acute paitents to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers, too. Beyond the waiver problem, however, home health care providers face other HCFA policies that tend to foreclose access to home care. To qualify for home health services under Medicare, a patient must be "homebound" and in need of only "intermittent" care. HCFA has so restricted the definitions of "homebound" and "intermittent" care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post acute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of post acute care services necessary to accommodate Medicare patients under DRG's. Hence, Medicare patients are being discharged from hospitals into a noncare zone.

AARP opposes the approach to deficit reduction embodied in the Gramm-Rudman amendment to the debt ceiling increase—House Joint Resolution 372. The association is alarmed at the size and growth of the Federal deficit; we strongly believe that this booming deficit portends irreparable harm to the Nation and that it must be reduced. That is why AARP has supported every deficit reduction bill for the past 4 years despite the deep cuts that have been made in programs vital to retired Americans. But, as it currently stands, Gramm-Rudman will cause extreme hardship to people who are most in need. The brunt of Gramm-Rudman falls on those domestic social programs that have already suffered high reduction since 1981. AARP believes that any deficit reduction mechanism must reach the defense budget in a meaningful way and must also control increases in the tax expenditures which are the two primary factors driving up the deficit.

We have an attached chart at the back that you can look at to see what this is all about. I don't think it is necessary for me to go into that at this time.

If there are any questions, I think that either I or Jack would be glad to help give you any information that might be needed.

Gramm-Rudman's emergency powers leave the growing problem of tax expenditures untouched.

Why would Gramm-Rudman cut basic health care benefits for millions of Americans while allowing financially healthy corporations to avoid paying their fair share of taxes?

Why would Gramm-Rudman cut lifeline programs such as Supplemental Security Income for the elderly, blind, and disabled while ignoring tax shelters which cost billions in Federal revenue?

Any deficit reduction plan must be fair. It must recognize the sacrifices made in previous deficit reduction efforts and who is best able to bear additional burdens.

AARP has always believed that it is possible to contain health care costs and still provide high quality health care. We continue with that belief. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and to coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change. We have spent the last 2 years attempting to moderate costs. It is time to give the same effort to quality of care. AARP therefore offers the following recommendations.

One, if the Congress refuses to increase DRG rates to at least the level recommended by the Prospective Payment Assessment Commission, then the transition to national rates should be frozen pending a thorough analysis of the impact of DRG's on the quality of care.

Two, the Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRG's. The changes should include formal hearing records and reported decisions under parts A and B as well as independent hearing examiners under part B.

Three, there must be a single national definition for "homebound" and for "intermittent" care. AARP favors either H.R. 2371 sponsored by Congressman Waxman or Senator Heinz's Home Care Protection Act, S. 778.

Four, AARP has long supported a mechanism to adjust for severity of illness within each DRG.

Five, AARP believes that HCFA must reevaluate its approach to quality of care issues through the PRO's. The role of the PRO's must be expanded to specifically require PRO's to monitor quality of care, both inpatient and outpatient and in post acute care settings. PRO's must be permitted to undertake longitudinal studies of patients' entire episodes of illness, from admission through discharge and including experiences in the post acute care setting. PRO's must be allowed the flexibility and given incentives to be innovative—to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training and consumer education ideas.

Six, the waiver of liability presumption for part A providers must not be revoked.

Seven, to validate the numerical reduction in identified medical procedures that HCFA required of the PRO's, AARP supports allocating 0.5 percent of HI revenues to study small area practice variations and to feed back the information to physicians.

I thank you, Mr. Chairman, for being able to testify on behalf of AARP.

[Testimony resumes on p. 257.]

The prepared statement of Mr. Heeren follows:]

PREPARED STATEMENT OF RUSSELL HEEREN

Good morning, Mr. Chairman. My name is Russell Heeren and I am a member of the National Legislative Council of the American Association of Retired Persons. On behalf of the 20 million members of the AARP, I want to thank you for this opportunity to state the Association's views on the Medicare DRG prospective payment system and its impact on the quality of health care. After having made substantial changes to the cost side of the Medicare health care equation over the last two years it is appropriate that we pause in order to assess what is happening to patients and the quality of their care. Increasingly, the question we at AARP and others are asking is "are we delivering health care for less, or are we just delivering less health care?"

My testimony today identifies two areas of concern about the implementation and operation of the DRG system so far: (1) The Health Care Financing Administration's (HCFA) failure to adequately monitor and correct for the economic incentives under DRGs to underserve patients; and (2) the serious lack of policy coordination and support of DRGs by contemporaneous HCFA policies. A third point we will make today is our concern about recent proposals to achieve deficit reduction and the likely impact on quality of care. Although we have additional concerns, most particularly the seeming lack of due process for the beneficiary faced with a noncoverage decision, we will focus this testimony on the need for a commitment to check the system's inherent incentives to skimp on services.

Following the discussion of these points, AARP makes several recommendations to improve the administration of DRGs, including changes in the Medicare appeals process, improved access and coverage for beneficiaries needing post acute care services, and innovative efforts by peer review organizations (PROs) to monitor and enforce standards for quality care.

HOSPITAL INCENTIVES UNDER THE MEDICARE DRG PROSPECTIVE PAYMENT SYSTEM

AARP is committed both to quality care and to a reduction in health care costs. We supported introduction of the DRG system in the belief that it had the potential to achieve both goals, but emerging evidence of harm to patients indicates that corrections are needed in the system.

The federal DRG system groups patients by major diagnostic categories. These are further divided by five variables that attempt to explain variation in resource consumption as measured by length of stay for different illnesses. This procedure results in 467 diagnosis related groups (DRGs).

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old "cost-plus" system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospital's interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, however, those incentives are gone.

Under DRGs, hospitals have the opposite incentives -- to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their "profit." Moreover, new administrative rules and policies under DRGs limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, the Health Care Financing Administration requires Peer Review Organizations (PROs) to reduce the number of identified procedures performed (the procedures vary from state to state) by specific amounts. PROs will be evaluated by HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, these numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Another example of a government requirement that places Medicare beneficiaries in jeopardy is HCFA's policy directive permitting hospitals to inform Medicare patients before admission, at admission, or during the hospital stay that certain services may not be covered by Medicare and that the patient is liable for payment if he or she goes forward with the treatment. This directive is a major new loop-hole in Medicare, and will result in greater out-of-pocket costs to beneficiaries, not to mention the possibility of deterioration in their health if they cannot afford continued treatment.

There are many similar examples, all reflecting the same theme: the incentives inherent in the DRG system, combined with the new rules implementing it, substantially alter Medicare patients' rights. This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways: (1) there is greater jeopardy to individual health status from skimping on services, and (2) there is greater financial liability for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required.

Evidence is mounting to demonstrate that patients are indeed sustaining harm under the implementation of this policy:

- In February, 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about the problems of early discharge and lack of post acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. Fortunately, the witness was knowledgeable about DRGs and was able to challenge the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and, therefore, are much more likely to acquiesce in the hospital's decision.
- On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting office on the impact of Medicare's new prospective payment system on post-hospital care. The report showed that Medicare patients run a substantially greater risk of being discharged "quicker and sicker," too often with no place to go.
- In July, Senator Heinz, Chairman of the Senate Aging Committee, announced that PROs had uncovered some 3,700 instances of inappropriate release or transfer of elderly hospital patients as of March 1985. Although the actual number of such cases has been challenged by HCFA, the point to remember is that the PROs are not uniformly making assessments on transfers and readmissions. The PROs that are committed to this task have reported over 4500 cases to HCFA regional offices as possible inappropriate discharges.

The American Association of Retired Persons is also trying to evaluate the scope and breadth of the problems affecting patient care under DRGs. The Association has received over 300 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. The stories that follow are illustrative of the anxiety and frustration encountered by Medicare beneficiaries and their families under the DRG prospective payment system.

- A 71 year old Medicare beneficiary in Texas, with an artificial heart valve, wrote about her own unhappy experience. (She is a retired R.N.) She was admitted to the hospital because of a high temperature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization.

  After being admitted she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital inhalation therapy was required for the entire night. In addition, although she was expectorating "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

  On the morning of the fourth day in the hospital her doctor announced she was going home. When she protested, he said that the hospital had a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset - even "intimidated" by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

  On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care; for such minimal care the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system in that hospital and learned, among other things: that the hospital has a medical review board consisting of doctors, nurses, and other hospital personnel, but (1) that, in this case, it is a medical librarian who makes the decisions about how long a patient can stay, and (2) that doctors are pressured to discharge patients as the hospital dictates.

* A visiting nurse in rural Iowa reports that, because of utilization review rules, one patient was sent home after hip surgery, despite the lack of adequate after-care at home. The hospital told the patient that they were "not allowed to take the home situation into consideration." Shortly thereafter, the patient pulled a muscle while trying to maneuver around unaided. Hence, the patient had to be sent back to the hospital for treatment.

The latter case illustrates what some observers are calling the "ping pong" effect: because of early release from hospitals, patients are not as well as they should be, and must eventually return due to complications. This phenomenon calls into question the success of cost savings supposedly achieved under the DRG system. Many health care providers suggest that the true result of this approach, in the absence of a developed in-home skilled care system, is simply cost-shifting to Medicaid, to Medicare beneficiaries, and to the patients' families. Worse, under DRGs, many Medicare patients are being discharged from hospitals into a "no-care zone," where they face further deterioration in their health.

A related development reported by some nursing home ombudsmen is that, as patients are referred to nursing homes with acute care needs, they are "bumping" older persons with chronic disabilities from the waiting lists, exacerbating the difficulty of gaining access to scarce nursing home beds for many who are eligible but perceived as less vulnerable. At the same time, many nursing homes find themselves ill-equipped to provide appropriate care for these more vulnerable patients. In response, some nursing homes hesitate to rely on descriptions given by hospital discharge authorities as to the condition of a patient about to be released, and make it a practice to call the floor nurse for more specific details. Such facilities may refuse to accept a patient whose needs they are unable to meet.

CONTEMPORANEOUS HCFA POLICIES AFFECTING DRGs

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRGs to discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post acute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities (SNF) have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNFs to become involved in Medicare, Congress provided a mechanism for "cushioning" SNFs against wrong decisions about whether a patient is covered for SNF care. This "cushion" is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent five percent or less of the provider's Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a proposed rule earlier this year, HCFA eliminated the waiver of liability by eliminating the presumption of good faith. The result of this change would be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post acute patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Beyond the waiver problem, however, home health care providers face other HCFA policies that tend to foreclose access to home care. To qualify for home health services under Medicare a patient must be "homebound" and in need of only "intermittent" care. HCFA has so restricted the definitions of "homebound" and "intermittent" care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post acute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of post acute care services necessary to accommodate Medicare patients under DRGs. Hence, Medicare patients are being discharged from hospitals into a no-care zone.

THE FEDERAL BUDGET AND DEFICIT REDUCTION

AARP opposes the approach to deficit reduction embodied in the Gramm-Rudman amendment to the debt ceiling increase (H.J. Res.372). The Association is alarmed at the size and growth of the federal deficit; we strongly believe that this booming deficit portends irreparable harm to the nation and that it must be reduced. That is why AARP has supported every deficit reduction bill for the past four years despite the deep cuts that have been made in programs vital to retired Americans.

But, as it currently stands, Gramm-Rudman will cause extreme hardship to people who are most in need. The brunt of Gramm-Rudman falls on those domestic social programs that have already suffered huge reductions since 1981. AARP believes that any deficit reduction mechanism must reach the defense budget in a meaningful way and must also control increases in the tax expenditures which are the two primary factors driving up the deficit. (See attached chart).

Gramm-Rudman's emergency powers leave the growing problem of tax expenditures untouched:

> Why would Gramm-Rudman cut basic health care benefits for millions of Americans while allowing financially healthy corporations to avoid paying their fair share of taxes?
>
> Why would Gramm-Rudman cut lifeline programs such as Supplemental Security Income for the elderly, blind and

disabled while ignoring tax shelters which cost billions in federal revenue?

Any deficit reduction plan must be fair. It must recognize the sacrifices made in previous deficit reduction efforts and who is best able to bear additional burdens.

There is a growing body of evidence that the quality of care for patients under Medicare and Medicaid is being compromised.

AARP RECOMMENDATIONS FOR STRENGTHENING THE MEDICARE DRG SYSTEM

AARP has always believed that it is possible to contain health care costs and still provide high quality health care. We continue with that belief. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and to coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change. We have spent the last two years attempting to moderate costs. It's time to give the same effort to quality of care. AARP therefore offers the following recommendations:

1. If the Congress refuses to increase DRG rates to at least the level recommended by the Prospective Payment Assessment Commission then the transition to national rates should be frozen pending a thorough analysis of the impact of DRGs on the quality of care.

Freezing the transition to the national DRG rates is necessary to help protect those hospitals that will be "losers" under the national rates. If the transition to national rates proceeds while government reimbursements lag behind appropriate adjustments for inflation then the "loser" hospitals will have even greater problems which, in turn, will affect patient care. Moreover, failure to halt the transition in the absence of adjustments would foster a two tier health care system with Medicare beneficiaries relegated to the lower tier.

2. The Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRGs. The changes should include formal hearing records and reported decisions under Parts A and B as well as independent hearing examiners under Part B.

3. There must be a single national definition for "homebound" and for "intermittent" care. AARP favors either H.R. 2371 sponsored by Congressman Waxman or Senator Heinz's HOME CARE PROTECTION ACT, S.778.

4. AARP has long supported a mechanism to adjust for severity of illness within each DRG. In the absence of such a mechanism, AARP is extremely cautious about

arbitrary cuts in the allowance for indirect medical education costs. The indirect medical education costs act somewhat as a proxy for a number of factors, such as severity, which may legitimately increase costs in teaching hospitals.

5. AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. The role of the PROs must be expanded to specifically require PROs to monitor quality of care, both inpatient and outpatient and in post-acute care settings. PROs must be permitted to undertake longitudinal studies of patients' entire episodes of illness, from admission through discharge and including experiences in the post-acute care setting. PROs must be allowed the flexibility and given incentives to be innovative -- to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training and consumer education ideas.

6. The waiver of liability presumption for Part A providers must not be revoked.

7. To validate the numerical reduction in identified medical procedures that HCFA requires of the PROs, AARP supports allocating 0.5 percent of HI revenues to study small area practice variations and to feed back the information to physicians.

Thank you again, Mr. Chairman, for this opportunity to share the views of the American Association of Retired Persons on this critical area of policy.

INCREASE IN THE DEFICIT ATTRIBUTABLE TO CONGRESSIONAL POLICY ACTION

(Fiscal Years; Billions of Dollars)

	1982	1983	1984	1985	1986	1987	1988	1989	1990	TOTAL
Legislative Changes										
Tax reductions	-41	-75	-99	-111	-130	-149	-162	-186	-228	–1181
Defense spending increases	-3	-16	-23	-35	-41	-53	-65	-79	-95	– 410
Nondefense spending cuts	40	48	50	38	63	69	73	82	88	+ 551
Effect of legislative actions on interest costs	a/	-3	-10	-21	-35	-50	-69	-93	-123	– 404
Total changes	-5	-45	-81	-129	-143	-183	-223	-276	-359	–1444

SOURCE Congressional Budget Office

Mr. Frost. Well, you have given a very full statement. It is interesting. I don't have too many questions. Let me touch on several matters in your recommendations starting on page 10, the bottom of the page.

In your first recommendation, you say that if Congress refuses to increase DRG rates to at least the level recommended by the Prospective Payment Assessment Commission, then the transition to national rates should be frozen pending an analysis of the impact of DRG on the quality of care. Now, there is a 1-year freeze in that transition in the bill that came out of the Ways and Means Committee that is pending in Congress right now in the reconciliation bill. In your judgment, how long could we freeze DRG reimbursment payments without having a serious impact on the quality of care?

We have a 1-year freeze in place for this year. What if the administration were to cut in and ask for another freeze next year as part of their Federal 1987 budget?

Mr. Christie. We couldn't favor, Mr. Chairman, another freeze at all. It is just too difficult and chancing the situation we are in. We are detecting quality of care problems at this point in the system. If we take the chance of freezing again the system without knowing what we are doing, we are running too great a risk.

Mr. Frost. When we had the administration representatives testifying before us several weeks ago, they indicated that they may well consider an additional freeze in 1987 and, of course, that will be up to this committee, then, to determine whether a freeze in DRG rates for Federal 1987 would make any sense or not, and that is one of the reasons we are having these hearings.

Mr. Heeren. I think one of the things that we must consider is how this will affect the senior citizen population if they are frozen. Are we going to keep the quality of care, or are we going to allow that to go down under this system by freezing the DRG's?

You see, the incentive then could be release the patients from the hospital even sooner without the proper care. That is what concerns us.

Mr. Frost. Release them into a system where they are being asked to pay more, as you mentioned in the——

Mr. Heeren. Not only more, but to not having the facilities out there to release them to. That is the big problem.

Mr. Frost. One other question. On page 11, down at the bottom, your further recommendation—you say AARP has long supported a mechanism to adjust for severity of illness within each DRG, and you go on to say in the absence of such a mechanism, AARP is extremely cautious about the arbitrary cuts in the allowance for indirect medical education costs and that these costs are somewhat of a proxy for a number of factors such as severity.

Well, I would only observe that, of course, not all the hospitals receive those indirect medical costs. That is only the teaching hospitals.

Mr. Heeren. Right.

Mr. Frost. And I am sure you are aware of that.

Mr. Heeren. Yes, sir.

Mr. Frost. So that I assume that even if we took care of this problem of continuing the indirect subsidy, that that still could cause problems in the system in not adjusting for severity of illness within each DRG cause of the hospitals that don't receive this subsidy.

Mr. **Heeren**. That is right, yes.

May I—being from New Jersey, we have had this DRG Program for 5 years now. We have the all-payer system which has helped a tremendous amount in situations just such as you are relating to, because all hospitals are covered under this program, and it has worked. We have problems. There is no question.

But that has helped, and we believe, I think, that the all-payer system is the way that the Nation should eventually go because it covers everyone.

Of course, I ought to state here, AARP is concerned because we have children and grandchildren out there, too. It is not just for seniors, but these costs are passed on to everyone.

Mr. **Frost**. If a hospital is limited to what it can receive under DRG's for treating Medicare patients, it will then up their cost for treating non-Medicare patients.

Mr. **Heeren**. Absolutely.

Mr. **Frost**. Your statement is very good. I appreciate your appearing before us.

I noted your comments about the Gramm-Rudman proposal. I am one of the conferees on the matter, and we will be continuing to meet on that subject this week, and we will take your advice to heart.

Thank you very much for appearing today.

Our next witness is Dr. William Felts, chairman of the Council on Legislation, American Medical Association.

Dr. Felts, I have read your statement over the weekend and there is something I would like you to address in your opening statement, if you would. After that, of course, proceed as you would like.

On page 8 of your statement, you say the AMA has recently issued two major reports on the Medicare Program. The first report identified a series of proposals that should be considered to assure solvency of the program for the short term, and the second report sets forth a series of assumptions for the Medicare Program.

Now, I don't believe that your testimony covers what was in these reports. If you can, to the extent of briefly summarizing what was in those reports, I think it would be very helpful.

STATEMENT OF DR. WILLIAM R. FELTS, CHAIRMAN, COUNCIL ON LEGISLATION, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, ASSISTANT DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. **Felts**. Thank you, Mr. Chairman. My name is William R. Felts, M.D. I am a physician in the practice of rheumatology in Washington, DC, and as you indicated, also chairman of the Council on Legislation of the American Medical Association. Accompanying me today is Bruce Blehart, of the AMA's Department of Federal Legislation.

We appreciate this opportunity to appear before you to address our concerns over the prospective pricing system, or PPS. The reports to which you refer and which are not present as attachments to this testimony have been, at least in part, submitted to some of the other committees of the Congress, particularly the first report relating to attributes of Medicare and the approach we feel should be basic to considerations of this program, with short-term reforms to maintain the solvency of the part A trust fund. We can make that available to you.

The second report establishes a basis to modify the current approach to funding for these programs in a way that would convert Medicare from a pay-as-you-go basis, to one where an individual can establish a trust fund on a prefunded basis, from which he and she can have their insurance funded as they grow older. The approach would encourage individual saving and keep individual responsibilities in the picture.

We are having this examined from multiple viewpoints including that of actuarial soundness before we are prepared to present it in a body such as this.

Mr. FROST. I would think that certainly the first report would be very helpful to this committee if you would make it available.

Mr. BLEHART. We would be pleased to provide copies of both of the reports to this committee for your information and for your use, hopefully.

[The reports referred to above may be found at p. 270.]

Mr. BLEHART. The first report specifically deals with short-term proposals that would be able to maintain the fiscal solvency of the Medicare Program. The second report goes into some specific guidelines and ideas for the long-term reform of the program to assure solvency well into the next century.

At this point, as Dr. Felts correctly pointed out, the association is looking in more detail at the second report trying to develop specific directions.

Mr. FROST. I appreciate that. I would just remind Dr. Felts that while there are several committees in both Houses that have substantive jurisdiction over the Medicare Program, all the action starts here, and that while we consult with those committees in drafting and preparing a budget for the next fiscal year, what we do in that budget has great influence and great impact on what those substantive committees are able to do in the fiscal year.

So you may proceed.

Dr. FELTS. Thank you, sir.

The years since enactment of Medicare have seen tremendous improvement in not only access to and the availability of high quality health care but also in the health status of the population that benefits from them. We certainly want these gains to continue. The American Medical Association is strongly committed to real reductions in health care expenditures that do not compromise the health of our citizens.

In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a 1-year period. Sixty-three percent of all physicians did not raise their fees for the entire year that the fee freeze request was in effect. This resulted in savings estimated at $3.1 billion that otherwise would have been spent for physicians' services. The AMA continues to urge physicians to consider each patient's financial needs and to accept Medicare assignment, reduce fees or charge no fee at all in the financial hardship cases.

This has benefited Medicare beneficiaries and the assignment rate has continued to climb with over 69 percent of all Medicare claims now accepted under assignment.

Mr. Chairman, this favorable action has occurred at a time when physicians face a crisis of nightmare proportions. This crisis is caused by increases in the professional liability litigation, and a lack of available insurance coverage at reasonable cost. This crisis poses a substantial threat to the ability of the medical community to meet the medical needs of our people.

The AMA supports Federal legislation that encourages States to enact tort reforms in an effort to avoid a paralysis of the health care system brought about by the increasingly threatening litigation climate.

The AMA also is deeply concerned with the impact of recent changes in the Medicare Program on the ability of physicians and hospitals to assure the continued availability of high-quality health care services for the Medicare population. The Medicare Program has been a principal focus of every budget reconciliation process since 1980 and has been subject to a continuing series of cuts and program modifications over recent years that have caused considerable stress and anxiety over the long-term ability of the program to meet the needs of its covered population.

Each budget year initiates a new series of proposals to reduce Medicare expenditures and ofttimes proposals are made to modify a newly enacted programmatic change such as the PPS even before it is fully implemented, much less evaluated.

We support an appropriate increase for Medicare reimbursements as provided by law, unless the Congress legislates an across-the-board freeze of all defense and domestic spending as a part of a broad program to reduce the Federal deficit and bring stability to the economy.

In response to your concerns over the impact of the PPS, I will summarize the ongoing results of AMA's DRG monitoring project initiated in June 1984 to determine how the PPS may affect the quality of patient care.

As of this September, 389 written responses, representing approximately 7,800 physicians, have been received by the AMA. Of the comments received concerning quality of care, 66 percent stated that the quality had deteriorated, concerns that related to early discharges, limitations on laboratory tests and hospital stays in which a second illness or condition requires treatment. Of the comments received concerning the cost of care, 85 percent reported that reimbursement in their hospitals was inadequate for one or more DRG's.

Areas of concern continue to be the severity of illnesses not appropriately accounted for in DRG's. Small or rural hospitals are continuing to experience loses on DRG's, and reimbursment is inadequate for some DRG's. Of the comments received concerning discharge policy, 43 percent reported pressure to discharge early. The AMA is continuing to study the effects of the PPS through the DRG monitoring project and through the use of surveys.

In addition, the association is currently working in conjunction with Johns Hopkins University to develop a series of research proposals that will result in a multifaceted study of the long-term effects of the PPS on the quality of health care. The AMA also is studying proposals for the longer range future, as I mentioned earlier, addressing new concepts to change the funding of health care for the elderly from the current pay-as-you-go Program to a self-funding system where resources will be set aside to provide real trust funds for the future.

We believe that such a program can be workable and is essential if we expect to end the annual budget crisis in health care programs.

In conclusion, Mr. Chairman, we strongly believe that the Medicare Program must be allowed to operate in a rational manner to assure availability of a quality health care system for the growing numbers of elderly that our country is seeing and will see in the near future.

Every year, Medicare has been targeted for cuts, freezes and major program modifications in the budget process. Continuation of Medicare is a primary focus to achieve domestic budget savings will provide a unfortunate environment where costs and not quality will dominate.

Mr. Chairman, the AMA hopes that this hearing acts as a catalyst for this Congress to commit itself to the maintenance of the Medicare Program that will assure the continued availability of high-quality health care services for our Nations' elderly and disabled.

[Testimony resumes on p. 299.]

[The prepared statement of Dr. Felts, with attachments, follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Task Force on Health
Budget Committee
United States House of Representatives

Presented by

William R. Felts, M.D.

RE: Hospital Reimbursement under Medicare
The Prospective Pricing System

October 21, 1985

Mr. Chairman and Members of the Task Force:

My name is William R. Felts, M.D., and I am a physician in the practice of rheumatology in Washington, D.C. I am also Chairman of the Council on Legislation of the American Medical Association. Accompanying me today is Bruce Blehart, Assistant Director of the AMA's Department of Federal Legislation. We are pleased to have this opportunity to appear before you to address our concerns over the provision of hospital care in hospitals paid under the prospective pricing system (PPS) for elderly and disabled Medicare beneficiaries.

The creation of the Medicare program in 1965 was a commitment to the elderly that this nation would assure them access to, and meet the major part of the cost of, high quality health care services. To a large extent that promise has been met. The years since the enactment of Medicare have seen tremendous improvement in not only access to and the availability of high quality health care but also in the health status of the covered population. One of the major reasons for this result has been the ability of the elderly to receive care in the same mainstream fashion as other individuals. We want these gains to continue.

The AMA is strongly committed to real reductions in health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Compliance with this freeze was substantial, with 63% of all physicians not raising their fees for the entire year that the fee freeze request was in effect. The resulting savings from this voluntary activity was an estimated $3.1 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services and in the over-all decrease in the nation's spending rate for health care services. Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases. This has been beneficial to Medicare beneficiaries and the assignment rate has continued to climb: over 69% of all Medicare claims now are accepted under assignment, although only 30% of physicians elected the "participating" status where they are obligated by law to submit all claims on an assigned basis.

Mr. Chairman, physicians today are facing a crisis of nightmare proportions caused by increases in professional liability litigation that in turn have caused a lack of available insurance coverage at reasonable costs. This professional liability crisis poses a substantial threat to the very ability of our nation to meet the medical needs of our people. The AMA is supporting federal legislation to encourage states to enact tort reforms to avoid a paralysis of our health care system brought about by the increasingly threatening litigation climate. The proposal supported by the AMA also would assure compensation for those who are injured through negligence.

The American Medical Association is deeply concerned, however, with the impact of recent changes in the Medicare program on the ability of physicians and hospitals to assure the continued availability of high quality health care services for the Medicare population. The AMA is strongly committed to assuring the availability of necessary services for the elderly. On November 12 and 13 of this year we will be sponsoring a national conference — cosponsored by the American Association of Retired Persons, the American Hospital Association and the American Nurses Association -- to explore ways in which these and other groups can work together to assure the continued availability of quality health care for the elderly. (A copy of the tentative program for this conference is attached to this statement.)

We also are concerned that further restrictions on the Medicare program may be placed on top of the changes made to the system for hospital reimbursement in 1983. The potential result of reduced access to health care services for the elderly and a decrease in the quality of care available simply may not be worth any gain in savings. This is extremely important since substantial modifications to the hospital payment rate under the PPS were recently recommended by the Senate Finance Committee and the House Ways and Means Committee.

Health Care and Budget Cuts

The Medicare program has been a principal focus of every budget reconciliation process since 1980 and has been subject to a continuing series of cuts and program modifications over recent years that have caused considerable stress and anxiety over the long-term ability of the Medicare program to meet the needs of its covered population. Each budget year initiates a new series of proposals to "reduce Medicare expenditures," and oftentimes proposals are made to modify a newly enacted programmatic change, such as the PPS, even before it is fully implemented.

There is an atmosphere of constant change and lack of stability in the Medicare program. Even now while hospitals, physicians and patients are experiencing a difficult time trying to cope with new initiatives and new directions, the Health Care Financing Administration (HCFA) is implementing additional new major program modifications without public input or even proper promulgation of regulations--leading to major lawsuits. These are exemplified by the regulatory actions to freeze the hospital payment level and to limit payments for graduate medical education.

It is especially frustrating that major program changes are undertaken without adequate consideration of their potential impact on patient care — now and in the future. The Administration and Congress are taking actions without waiting for the results of studies that they have ordered.

The American Medical Association is opposed to a freeze on hospital reimbursement in the absence of a showing that access to and quality of care would not be adversely affected and cost-shifting would not be increased by such a freeze. We support an appropriate increase for Medicare hospital reimbursement as provided by law, unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the federal deficit and bring stability to the economy.

The AMA's DRG Monitoring Project

The American Medical Association initiated its DRG Monitoring Project in June 1984 to determine how PPS may affect the quality of patient care. The Association has sent letters to the chiefs of the medical staffs of over 6,000 hospitals asking them and physicians they work with to share information with the AMA concerning their experiences, both positive and negative, which they feel are attributable to their hospital's participation in the PPS program. As a follow-up to the initial mailing, a second mass mailing was made on August 30, 1984 and announcements about the Monitoring Project have been sent to state medical and national medical specialty societies. Announcements also have been published in AMNews and other publications.

As of August 31, 1985, 389 written responses representing approximately 7800 physicians have been received by the AMA. Comments were provided by physicians in 40 states, 20 different medical specialties, teaching and nonteaching institutions, and urban and rural areas. A majority of the responses were received from chiefs of medical staffs who incorporated the comments of their entire medical staffs. Several chiefs of staffs conducted their own surveys and forwarded the results to the DRG Monitoring Project. These responses can be partially summarized as follows:

- Of the comments received concerning quality of care, 66% stated that the quality had deteriorated. Concerns have related to early discharges, limitations on laboratory tests and hospital stays in which a second patient condition or complication requires treatment.
- Of the comments received concerning the cost of care, 85% reported that reimbursement in their hospitals was inadequate for one or more DRGs. Areas of concern continue to be that severity of illness is not appropriately accounted for in DRGs, small or rural hospitals are continuing to experience losses on DRGs, and reimbursement is inadequate for some DRGs.
- Of the comments received regarding length of stay (LOS), 65% stated that LOS had decreased under PPS. An additional 25% questioned the appropriateness of LOS for certain DRGs.
- Of the comments received concerning discharge policies, 43% reported that there was pressure to discharge patients early, and 32% reported that policies had changed for the better.
- Of the comments received addressing administrative relations, 42% reported a deterioration in administration/physician relations, and 28% reported an improvement in such relations.

The AMA is continuing to monitor the effects of the PPS through the DRG Monitoring Project and through the use of surveys. In addition, the Association is currently working in conjunction with Johns Hopkins University to develop a series of research proposals that will result in a multi-faceted study of the long-term effects of the PPS on the quality of health care for Medicare beneficiaries. We will be pleased to keep this Committee informed of our research efforts.

Additional PPS Concerns

At a time when hospitals and physicians are trying to cooperate with the PPS during its implementation and while the review of the impact of this system is still in the process of being conducted by the Prospective Payment Assessment Commission (PROPAC), we feel it is highly inappropriate to impose a freeze on the existing reimbursement rates. Also, the AMA is by no means alone in studying the PPS or raising questions about its directions and future.

- The HHS Office of the Inspector General has planned a variety of studies which will, among other issues, examine the quality, medical necessity and appropriateness of patient care under the PPS. A just initiated study will examine all cases referred to HCFA Regional Offices from October 1, 1983 to May 31, 1985 to determine disposition of inappropriate discharges and transfers.

- A GAO report from last February reported that Medicare spending restrictions are prompting hospitals to send elderly patients home quicker and sicker, sometimes needing more intensive care than is available.

- A study of the effects of the PPS on community-based long-term care services for the elderly (conducted by the Southwest Long Term Care Gerontology Center of the University of Texas Health Science Center at Dallas in cooperation with the National Association of Area Agencies on Aging; reported September 1985) concluded that the demand has increased for community-based in-home services, such as nursing care and home delivered meals, due to older patients leaving hospitals "quicker and sicker" than was the case prior to implementation of the PPS.

- A September 26, 1985 staff report issued by the Senate Special Committee on Aging was characterized by the Committee Chairman, Senator John Heinz, as finding that: "(1) seriously ill Medicare patients are being denied admission to hospitals or catapulted out of hospital doors prematurely as a result of inflexible, inaccurate pricing and packaging of illnesses; (2) patients are judged as DRG winners or losers, depending on the profit potential they represent under the current payment system; and (3) DRGs have created a dilemma of medical ethics versus profitable hospital practice, as the financial incentives provided by the DRGs result in hospitals pressuring doctors to violate their own medical judgment in treating patients."

Long-Range Analysis and Solutions

With a program as important and complex as Medicare, we believe that modifications should be viewed in the broader context of providing health care for the elderly and disabled today and well into the next century. The American Medical Association has taken a lead role in looking for long-range solutions to today's and tomorrow's health problems. The AMA has recently issued two major reports on the Medicare program. The first report identified a series of proposals that should be considered to assure solvency of the program for the short term. The second report sets forth a series of options for the Medicare program. The Association is studying proposals to utilize new concepts to change funding for health care for the elderly from the current pay-as-you-go program to a self-funding system where resources will be set aside to provide real trust funds for the future. We believe that such a program can be workable and is essential if we expect to end the annual budget crises in health care programs.

Conclusion

Mr. Chairman, the AMA is deeply concerned about the potential for deterioration in the quality of health care available in this country. We strongly believe that the Medicare program must be allowed to operate in a rational manner to assure the availability of a quality health care system for the growing numbers of elderly that our country is seeing and will see in the near future. Every year Medicare has been targeted for cuts, freezes and major program modifications in the budget process. Continuation of Medicare as a primary focus to achieve domestic budget savings will provide an environment where costs, not quality, will dominate.

The AMA hopes that this hearing acts as a catalyst for this Congress to commit itself to the maintenance of a Medicare program that will assure the continued availability of high quality health care services for our nation's elderly and disabled.

Attachments.

LL. REPORT ON THE MEDICARE PROGRAM
(Reference Committee A, page 388)

HOUSE ACTION: ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 34 for report to the House of Delegates at the 1984 Interim Meeting:

SYNOPSIS

In view of the approaching fiscal crisis in the Medicare Part A trust fund, the AMA Board of Trustees requested a comprehensive policy review of the Medicare Program by the Council on Medical Service and the Council on Legislation. In their comprehensive review of the Medicare program, the Councils initially considered a broad range of policy options and potential responses to these problems. The Councils rejected certain options, developed specific proposals on others, and identified still others for further in-depth study. The Board of Trustees has considered the Council's views and has prepared this report for consideration by the House of Delegates.

The Board and Councils firmly believe that, while further in-depth study as to the desirability and practicality of certain comprehensive changes in approaches to financing care for the elderly are under study, there is a need for interim solutions to the fiscal and political problems facing the Medicare Part A trust fund. The Board and Councils emphasize that any comprehensive changes in the method of financing medical care for the elderly would take considerable time to phase in. The needs of beneficiaries must be protected during any period of change. For this reason, the fiscal solvency of the Part A trust fund is a crucial interim issue which must be successfully addressed.

This report presents a series of "Guidelines for Review of the Medicare Program." These guidelines were developed jointly by the Councils on Legislation and Medical Service and have been approved by the Board. They provide a framework for consideration of interim solutions, without restricting consideration of various alternative options which will be under continuing in-depth study for potential major modifications in financing of care for the elderly.

Specific interim actions are presented in this report. Pertinent AMA policies, as well as applicable proposals made by the Advisory Council on Social Security and by participants at the Congressional Budget Office (CBO)–House Ways and Means Committee Conference on Medicare are referenced after each interim action.

In addition to conclusions set forth in this report, areas recommended for continuing in-depth study are described, and appendices on the fiscal impact of some possible Medicare program changes (Appendix A) and the recommendations of the Advisory Council on Social Security (Appendix B) follow this report.

BACKGROUND

The Board of Trustees, with the assistance of the Council on Legislation and the Council on Medical Service, has reviewed the multiple factors which have contributed to the current financial difficulties of the Medicare program.

ENVIRONMENTAL REVIEW

As a starting point, the Councils presented to the Board information regarding the enactment of the Medicare Program, various modifications which have been made to the program since its enactment, the scope of and the political environment surrounding the current program, and the forces which have been driving the Medicare system toward a financial crisis. The essence of this environmental review is set out below.

HISTORICAL PERSPECTIVE ON THE PROGRAM

Congress enacted Medicare in 1965. The AMA strongly opposed that action, urging instead that the financial resources of government should be targeted toward those elderly persons who were in financial need. The Association predicted that the costs for Medicare would far exceed the projected expenditures and that pressures within the system would demand expansion. Congress would not accept an alternative (Eldercare) proposed by the Association aimed at providing health care financing for the elderly in need.

One of the perceived failures of the health care system at that time to which the Congress responded was an unavailability of insurance for and lack of adequate coverage of the elderly (age 65 and over). (For that matter, broad assertions were made concerning lack of insurance coverage of the population as a whole, including the work force. In spite of the fact that the health insurance industry was beginning an expansion to meet the needs of employers, employees and the public, progress was regarded as "too little, too late.") The inability of the elderly to afford insurance coverage even where it was available and expenditures for health care as a high percentage of their income were additional charges against the health care system of that time. Medicaid, enacted with Medicare, revamped the former Kerr-Mills program of assistance for the aged needy, providing additional health coverage for the needy Medicare population.

Medicare and Medicaid were enacted at the beginning of a period marked by expansion of federal government involvement in social programs. The "Great Society" programs of the mid-sixties embraced new segments of the population and provided a wide array of social services. A variety of health programs were included. For many years "health" was a fundamental issue commanding a prominent place in the political scene. Almost limitless funds were being poured into varying aspects of the health system:

- Basic research was greatly expanded resulting in new scientific breakthroughs and technology.
- Hospitals modernized and expanded throughout the country as a result of the Hill-Burton program of federal financial assistance.
- Health manpower development burgeoned with expansion of federal assistance to medical and allied health schools and their students.

It is within the context of expanded federal assistance for facility development, for manpower expansion, for health research and dissemination of medical knowledge, and expansion of alternative delivery systems that the federal medical programs providing payment for medical services completed a circle of large scale encouragement and direct financial support for the health care system.

During the decade or so following enactment of Medicare, access to care was to a large extent provided to the covered population, and the expectations of the nation's elderly for health care coverage through Medicare grew. These expectations were fueled by the Congress, which reacted to a variety of pressures, including those of an increasing elderly population which had established itself as a growing political force. Congress expanded the Medicare program, and extended coverage to new population groups – the disabled and those with end-stage renal disease (ESRD). The Congress had clearly made a major commitment to large segments of the U. S. population that high quality care would be made available and paid for. Health care as a "right" became a central theme in the 1970s in discussions on health care. What Congress had created was a situation of expanding beneficiary rolls and increased beneficiary expectations. During this era primary attention was focused on quality rather than costs.

In the main these developments occurred in an era of relative national affluence. But because of program expansion, the cost-based reimbursement methodology under Part A, the increase in numbers of Medicare beneficiaries and in per capita use of covered services, the rapidly expanding availability of providers, and the growing rate of inflation in the economy as a whole, the costs of Medicare and Medicaid were escalating sharply. Concerns over these new developments in those programs resulted in greater governmental regulation of health care delivery.

Aside from early Medicare regulations, the heavy hand of cost control and program regulation was cast in 1972 Medicare Amendments when Congress imposed new controls on hospital reimbursement, capital expenditures, and new controls on physician fee increases. Later modifications especially affecting hospitals were adopted, resulting finally in a major restructuring of hospital reimbursement in 1983 through the prospective pricing system – DRG.

Unfortunately, the economic vitality of the country did not keep pace with increasing demands of federal programs and expenditures. The federal government became faced with serious economic problems, including budget deficits, falling tax revenues, and record unemployment. National needs other than for health were given increased emphasis in the national budget. In the light of many economic, social and technological changes, Medicare is coming under close scrutiny. Because of increasing annual federal deficits (i. e., from $60 billion in 1980 to $180 billion projected for 1984), fundamental changes – even the mention of which would have been unthinkable only a few years ago – are now freely discussed in many quarters. These discussions have entered even the halls of Congress which had given birth and shape to the program with its many promises to the American public.

FORCES DRIVING PROGRAM TO FINANCIAL CRISIS

The Board concurs with the Councils that a recognition of the basic forces driving the current program toward financial crisis and of the political environment supporting the current program are particularly important to consideration of broad policy options regarding the Medicare program. As identified by the Councils, the basic forces driving the program toward a financial crisis are:

- An aging population;
- High per capita health care costs for the elderly;
- The decreasing proportion of workers to beneficiaries;
- The inability of government to financially meet all its obligations and promises;
- Rising total health care costs;
- Expanding medical technology;
- Increasing professional liability costs including the costs of defensive medicine; and
- General inflationary forces.

The Board reviewed extensive material on these basic driving forces, much of which had also been the basis for the Board's Report D (I-83) on Health Care for an Aged Population.

Several important observations in this area are:

- In the next fifty years the population over 65 will more than double and the population over 85 will more than triple.
- The ratio of workers to elderly will decrease from 5:1 in 1990 to 3:1 in 2025.
- As the proportion of older people in the population increases, the requirements for acute and long-term care will increase.
- Although comprising 11 percent of the total population, elderly patients make 30 percent of all patient visits to office-based physicians.

- Forty percent of total hospital inpatient days are used by elderly patients. In 1978 short-stay hospital admissions for persons age 65 and over were about 350 per thousand population, while for those under 65 the figures were about 132 per thousand population. Older patients have an average length of stay 76 percent greater than younger adults.
- The elderly occupy 90 percent of nursing home beds.
- Persons over 65 incurred 3.5 times the per capita health care expenditures of persons under age 65. Almost two-thirds of these expenditures are covered through Medicare and Medicaid.
- Over 97 percent of private nursing home expenditures are out-of-pocket expenses for the aged and their families, uncovered by Medicare or private insurance.
- Between 60 percent and 80 percent of the long-term care the disabled elderly receive in the community is provided informally by a spouse, other relatives, and/or friends. The presence of a spouse and/or children is the most important factor determining whether or not a disabled elderly patient will enter a nursing home.

The relationship of tax payments by workers to the cost of benefits received by beneficiaries has a number of especially important political and economic implications, particularly in view of the likely continuing decrease in the proportion of workers contributing to Medicare through the Health Insurance (HI) tax compared to the number of Medicare beneficiaries.

Findings presented to the National Advisory Council on Social Security show a marked discrepancy between the amount of payroll taxes paid to the program and the cost of benefits received by the average beneficiary. In 1982, HCFA's Office of the Actuary estimated that "beneficiaries who had worked during the entire period that the HI payroll tax has been in effect, 1966-1982, had made accumulated contributions of between $1,120 and $3,740. The average contribution made by a beneficiary was $2,200. The estimated cash value of Medicare benefits for persons reaching age 65 in 1982 was $28,000 for men and $32,000 for women. The anticipated cash value of benefits to be received by new beneficiaries was 7.5 – 28.6 times greater than the amount each beneficiary contributed." This imbalance between pay-in and pay-out, which is expected to persist,* demonstrates that the widely held concept of Medicare as an "entitlement" or "earned benefits" system in which tax contributions are at least roughly proportionate to benefits received is erroneous, and that income transfer of significant extent currently occurs in the program. This imbalance between contributions made and benefits received is hardly surprising, in view of the fact that Medicare covers the most expensive period of life in terms of health care, and is for the majority of the population the primary payor for expenses of terminal illness. **However, this imbalance is not widely recognized, and the Board believes that greater understanding of its existence is critical to more widespread public acceptance of the need for greater contributions to defraying costs of the program.** Further, and precisely because income transfer is from current workers to current beneficiaries, the Board believes that new emphasis should be directed toward increased contributions by beneficiaries.

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*The Board and Councils recognize that this imbalance may be reduced somewhat as individuals arriving at eligibility age have progressively more years of tax contributions behind them (Medicare is only 19 years old). However, this reduction could be more than offset by further increases in life expectancy and by use of new and more costly technology. The Board further recognizes that not all potential Medicare beneficiaries will reach age 65 or older. Persons not reaching age 65 (and not becoming totally disabled at a younger age) will pay into but not receive benefits from the program. However, it should be noted that as of 1981 over three-fourths of all newborns could expect to reach age 65 and that average life expectancy reached age 74. In 1982, the percentage of the total population in the 75-84 age category was 3.6 percent or 8.2 million, with 1.1 percent or 2.5 million in the 85 and older category. By the year 2050, the 75-84 category is expected to reach 6.8 percent (21 million) of total population and the 85 and older category is expected to reach 5.2 percent (16 million) of total population.

The Board has reviewed the projections of the Trustees of the Part A fund in their 1983 report as to when the fund is likely to be depleted. Such projections ranged from as early as 1988 to an "optimistic" outlook of 1996. The Board is also aware of the very recently reported projections of the Congressional Budget Office indicating that the financial condition of the HI fund has improved significantly in the past year. CBO reported in February 1984 that, largely as a result of the improving economy and lower hospital bills, the projected 1989 balance in the HI fund has risen from $8 billion to $30 billion.

The most recent CBO projections are indeed encouraging. However, it should be emphasized that such projections, if they prove to be correct, are likely to result in only a temporary delay in the projected depletion of the fund – possibly a delay of only two years. Thus the Board believes – as do the Councils – that changes in the program are needed notwithstanding the improving economy.

REVIEW OF BROAD POLICY OPTIONS

The Councils and the Board considered a broad range of basic policy options relating to financing of medical care for the elderly and disabled. These broad policy options were:

- Maintain the Medicare program with no change;
- Maintain the Medicare program with modifications in existing financing and with no change in benefits, payment mechanisms or eligibility;
- Maintain the Medicare program with modifications in benefits, payment methods, and financing;
- Replace the Medicare program with a new federal program;
- Replace the Medicare program with a new combined federal/state program;
- Replace the Medicare program with tax incentives to encourage purchase of private insurance by the elderly, but continue federal and/or state financial assistance to the needy elderly; and
- Terminate the Medicare Program, with no special provisions for the elderly and disabled.

Within each of these broad policy options, the Councils and the Board reviewed a number of specific alternative approaches, some of which are recommended in a later section of this report for further in-depth study. However, the Councils and the Board believe that even if desirable and practical alternatives for financing health care for the elderly are proposed, it would take considerable time to phase in any such alternatives and that the continuing fiscal solvency of the HI fund is an issue which must be addressed for the interim.

The Councils and the Board believe that it would be unrealistic to recommend any broad scale replacement of the Medicare program at this time. Further in-depth studies of both the current program and alternative methods of financing medical care for the elderly must continue while efforts are made to address the imminent fiscal problems of the Part A trust fund.

As indicated previously, the Board is sensitive to the many political implications surrounding changes in the Medicare program. Medicare is the primary source of financing of health care for 26 million elderly and 3 million disabled persons (1982 figures). This fact combined with support for the program from families of beneficiaries, provider groups and others, provides a powerful political force for support of the Medicare program.

Since the proposals in this report for addressing the financial problems of the Part A fund would impact on a variety of groups (i. e., workers, beneficiaries, hospitals, physicians) and certain others such as the alcohol and tobacco industries, the Board recognizes the potential for varying levels of adverse reaction to the specific recommendations contained in this report.

The 1984 elections provide a series of factors that make detailed projections of the future climate uncertain. While it is expected that health care in general and Medicare in particular will be a major topic of debate during the election process, it is not expected that major activities or modifications to Medicare will result in 1984. Questions of timing on the utilization of the information and recommendations contained herein will be addressed by the Board in order to determine the most appropriate time for any public comments by the AMA on this issue. The Board and Councils concur in the need for continuing reevaluation and updating of the data and projections presented herein on program costs and projected savings, as economic and other environmental circumstances change.

GUIDELINES FOR REVIEW OF THE MEDICARE PROGRAM

Having concluded that Medicare, with appropriate modifications, should continue to finance health care needs for the elderly and disabled, during the period when the desirability and practicality of a broad range of alternatives are examined, the Board has approved the following "Guidelines for Review of the Medicare Program," which were developed by the two Councils. Of necessity these guidelines impact on one another. Accordingly, they should not be evaluated individually but rather must be considered as a whole to determine whether or not suggestions for programmatic modifications fit within these guidelines. The specific recommendations in the next section of this report are consistent with these guidelines.

The guidelines are:

1. Access to quality health care for the elderly and the totally disabled through Medicare should be assured. Responsibility for access should be shared by the federal government, the states (e. g., through Medicaid), providers and beneficiaries.

2. The program should be on a fiscally sound basis to meet present and future needs in order to maintain access to quality care for Medicare beneficiaries.

3. All beneficiaries under Medicare should have access to the same range of program benefits, and should share in the program's cost in a way which encourages responsible use of medical resources. There should be a cost sharing limit to protect the patient from catastrophic medical expense.

4. Medicare should provide payment for necessary medical services. It should be sufficiently flexible to make appropriate accommodations for new medical therapies and new technology. Expansion of benefits other than for medical services should not divert Medicare resources.

5. Medicare should assure freedom of choice of physician, provider, or system of health care delivery.

6. Medicare should encourage delivery of services in cost-effective settings consistent with appropriate quality of care.

7. Medicare should meet its obligation to pay its full share for promised benefits. Payment for services should be sufficient to assure reasonable access to those services. Physicians should consider accepting, as payment in full, the Medicare approved amount of charges* for those beneficiaries for whom additional payment would be a hardship.

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*"Approved amount" is synonymous with and replaces the term "reasonable charge" previously used by the Medicare program, and recognizes the beneficiary's obligation for coinsurance.

8. Congress should periodically alter the age of eligibility to recognize changing trends in terms of employment, health status, and longevity of our citizens.

9. Medicare, along with other insurers and payors of medical care services – all of whom benefit from the medical education system – should continue to support medical education.

10. Medicare eligibility should not be expanded beyond the categories (aged, disabled, ESRD) currently recognized in the law.

11. Cost sharing based on ability to pay may be considered when administratively feasible and necessary to ensure the fiscal integrity of the program.

AREAS FOR CONTINUING IN-DEPTH STUDY

The Councils and the Board have discussed a number of alternative approaches to financing or providing health care for the elderly and the disabled. The Board has requested the Councils to continue expeditiously to evaluate the complete scope of available options for modification of financing health services for the elderly and to assess the desirability and practicality of such options. Such options would include the following:

Health Insurance Individual Retirement Accounts (IRAs) – Such an account could serve as a mechanism to provide for basic health coverage for the elderly and therefore to transfer the emphasis in Medicare to a catastrophic program. The Board views this as a promising long-term alternative. However, such a program would have to operate in tandem with the existing Medicare program for sufficient time to allow for an appropriate transition to allow such an account to adequately fund expected health care needs.

Universal Vouchers – This option could lead to private sector financing of health care for the elderly. The Board recognizes that major problems need to be worked out before this option could be implemented including the problems of adverse selection, pricing of the voucher and the assurances of the availability of private coverage in all areas of the country. Accordingly, feasibility initially should be tested on a local demonstration basis.

No Special Federal Program for the Elderly, Other than Low-Income – This option would assume that there are no special needs that need to be addressed by the federal government related to the health care of the elderly population in general. The Board believes that this option would require extensive review of the ability of the elderly population to support their own health care needs in light of increased life expectancy and expensive new technology.

Post-Retirement Employment-Based Coverage – This option could require the creation of special tax incentives similar to those available for providing health insurance coverage for the employed population. A variation of this concept could involve the establishment of plans similar to employer-sponsored pension plans to fund health care coverage. The Board is especially cognizant of the concern that such a proposal would generate within the business community, in light of the impact that this type of proposal could have on total labor costs.

Family Responsibility – This option could recognize the value an individual has in assets through payment from a decedent's estate for a proportion of Medicare benefits that are in excess of the individual's prior contributions. This option could also provide tax incentives for the family.

Combined Medicare – Private Sector Approaches – This option assumes that the Medicare program would be revised to permit additional options to coexist aimed at increased private sector involvement in the system. This might include a totally private program or the availability of vouchers. Medicare could continue for some individuals and could be modified to provide beneficiary payments based on ability to pay. Under this proposal, it would be essential to coordinate and integrate benefits to account for contributions already made to Medicare by potential future beneficiaries, and to enable beneficiaries to have available comprehensive coverage suitable to individual needs.

INTERIM PROPOSALS

Based on initial review by both Councils of an exhaustive list of possible interim approaches, those approaches perceived as equitable and consistent with continued quality and accessibility of care were selected by the Councils for further exploration and development of specific proposals. The Board reviewed the recommendations of the Councils, and the specific proposals presented below, approved by the Board essentially call for increasing program revenue and reducing program costs by (1) tax changes, (2) beneficiary cost sharing or deferment of eligibility for benefits, and (3) special payment arrangements by physicians for low income beneficiaries. In this way no one segment of society is required to carry the full burden of maintaining the program.

The hospital industry may seem conspicuous by its absence from this list of potential contributors to a solution. However, it is a reasonable assumption that the newly instituted DRG-based prospective pricing system for hospital services to Medicare beneficiaries will, over time, exert increasing incentives on hospitals to be prudent purchasers as well as purveyors of goods and services, as the DRG payment rates become progressively less derived from the hospital's own cost base, and as methods to include payment for capital-related costs within the DRG system are developed and applied. On that assumption, the hospital's "contribution" to trust fund solvency has already been factored into the future spending estimates under Table 1 (see Appendix A), through the time period covered by the table, in the sense that the DRG-based system is assumed to be successful in allowing no more than a 1 percent yearly increase in hospital reimbursement over and above those "market basket" price increases over which the hospital has no direct control.

(1) REVENUE INCREASES

The Board considered three possible approaches to increase program revenue through changes in the tax structure: (a) increasing the health insurance payroll tax rate; (b) increasing taxes on alcohol and tobacco products; and (c) imposing the Health Insurance Part A tax on non-wage income.

(a) Increasing the payroll tax rate: Under current law, the HI trust fund is principally funded through taxes paid by workers and their employers, and by individuals with self-employment income. The tax rate that both employees and employers must pay is 1.3 percent each, or a combined 2.6 percent rate. This is scheduled to increase to 1.35 percent (2.7 percent combined) in 1985 and to 1.45 percent (2.9 percent combined) in 1986. In addition, the tax rate for self-employed will increase in 1984 to 2.6 percent.

> ACTION: The Board approved support for an additional moderate one-time increase in the payroll tax rate on employers and employees, effective in 1985 or as soon thereafter as practical.

RATIONALE: Government actuaries have estimated that the combined health insurance payroll tax rate would have to be increased to 5.13 percent by 2005 in order to completely cover program expenditures by that date. The Board believes that a tax rate increase of that magnitude, while attractive as an "instant solution" to trust fund deficits, is neither politically feasible nor desirable, given the predicted future decrease in number of workers per beneficiary and potentially adverse effects on employment and business activity. However, in line with the Board's conviction that multiple approaches are necessary, and consistent with the concept that payroll contributions should have more relationship to future benefits received, the Board believes that a more modest increase in the health insurance payroll tax rate, for example an additional increase of one quarter of one percent to both employer and employee (0.5 percent combined) is entirely appropriate as part of an overall solution. As indicated in Appendix A, such an increase will produce significant additional program revenue ($9 billion in 1985 and $17 billion in 1995). At the same time, the financial impact on employer and employee will be relatively modest; an employee earning the taxable maximum will pay an additional $102/year or $8.50/month in 1985, as will his employer.

PERTINENT AMA POLICY: In testimony to the House Ways and Means Committee in 1983 the Association suggested that Congress may wish to consider increasing the HI portion of the Social Security FICA tax on employees and employers.

RECOMMENDATIONS OF OTHER GROUPS:* The Advisory Council on Social Security opposes any further increase in HI payroll tax rates beyond those now scheduled. One proposal at the November 1983 Ways and Means Conference identified increases in the HI tax rate as one of eight tax changes meriting consideration.

(b) Increasing the alcohol and tobacco tax rates. The imposition of additional taxes on alcohol and tobacco and designation of such tax revenue to the HI trust fund has been suggested. The federal excise tax on cigarettes was raised to $0.16 per pack in the Tax Equity and Fiscal Responsibility Act of 1982. Under this law, the rate returns to $0.08 on October 1, 1985. Federal tax rates for alcoholic beverages have remained unchanged for the last thirty-two years. Under the current tax structure, liquor is taxed at $.164 per ounce of ethanol, beer is taxed at $.057 per ounce, and table wine at about $.011 per ounce. These tax rates equate to $1.81 on a fifth of 86-proof liquor, $.16 on a six-pack of beer, and $.17 on a gallon of wine with a 12 percent alcohol content.

> ACTION: The Board approved support for an increase in the present tax rates for alcohol and tobacco products, effective in 1985 or as soon thereafter as practical, with the additional revenues directed to the Hospital Insurance trust fund.

RATIONALE: The Board recognizes the political sensitivity surrounding this issue, and the reluctance in some sectors to tax human "frailties." However, the Association has in numerous past reports and statements emphasized the need for treating alcohol abuse and addiction to tobacco as serious medical problems, and for multifaceted efforts to prevent these physically and socially detrimental behavior patterns. The AMA's Council on Scientific Affairs estimated that 346,000 U. S. deaths in 1979 were attributable to smoking. In that same year, the cost to employers alone of absenteeism and reduced productivity associated with employee alcohol abuse was estimated at $78 billion. According to a study conducted by the Institute of Policy Sciences of Duke University, a doubling in the tax rate on liquor would result in a reduction in cirrhosis mortality by approximately 20 percent. In addition, the tax would be most heavily focused on the 10 percent of the adult population that consumes about 50 percent of all alcoholic beverages sold each year in the United States.

In view of the demonstrated correlation between use of alcohol and tobacco products and increased health care costs, the Board believes that increased taxation of these products is one of the most fair and equitable of the revenue enhancement measures available. (As indicated in Appendix A, if such a tax change were effected, a 50 percent increase in the tax rate on alcohol and tobacco, beginning in 1985, would produce an estimated $5 billion in additional revenue that year, and almost $10 billion in 1995.) Although the AMA has opposed the earmarking of specific tax revenues for specific health programs as a general principle, the Board believes that the designation of such specific taxes to the Part A trust fund without disease or other categorical program restrictions is appropriate and should be supported.

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*Recommendations reviewed were those adopted by the Advisory Council on Social Security and those presented at the November 1983 CBO Ways and Means Conference on the "Future of Medicare."

PERTINENT AMA POLICY: The Association has supported increases in the tax on tobacco products. There is no specific policy regarding increase in the tax of alcohol products. Association policy has previously recommended against earmarking of general revenue raising taxes for specific health programs.

RECOMMENDATIONS OF OTHER GROUPS: The Advisory Council on Social Security supports an increase in alcohol and tobacco tax rates with revenues earmarked for the HI trust fund. The Ways and Means Conference also identifies increases in the tax rate on alcohol, tobacco and gasoline as one of eight tax changes meriting consideration.

(c) Taxing non-wage income: The present HI tax is levied only on payroll and self-employment income; such non-wage income as interest, dividends, etc., is not affected. Imposing this same tax on all non-wage income above a certain dollar threshold (say $12,000 annually or roughly twice the poverty level of $5,917 for a two-person family) and up to the maximum amount subject to the HI payroll tax under current law would produce some increase in revenue.

> ACTION: The Board approved support for imposing the Health Insurance tax on the non-wage income of individuals above a certain threshold and up to the taxable maximum.

RATIONALE: The Board believes that equity and fairness require that all citizens face the same relative tax burden to fund the program, regardless of the source of that income. The Board also notes that exempting the first $10,000 or $12,000 of non-wage income would avoid regressive, first-dollar taxation on non-wage income of retirees.

PERTINENT AMA POLICY: The Association has no policy on this specific issue.

RECOMMENDATIONS OF OTHER GROUPS: None

(2) BENEFICIARY COST SHARING OR DEFERMENT OF BENEFIT ELIGIBILITY

The Board considered potential approaches to reducing program spending through: (a) payment by beneficiaries of a Part A and/or an increased Part B premium, with premium amounts either scaled to income or the same for all; (b) increased beneficiary coinsurance for hospital care with cost sharing limits again either related to income or the same for all beneficiaries; and (c) raising the age of Medicare eligibility.

(a) Beneficiary payment of a Part A Premium: A substantial number of the 29 million Medicare beneficiaries have assets and income well above twice the "poverty level" of $5,917 for a two-person family. The average after-tax income per family member in the 65 and older category is $6,299 as compared to after-tax income of $5,964 per family member in all households. A number of proposals have suggested that beneficiaries be charged a Part A premium, with the amount of the premium either based on income status or being the same for all. Appendix A shows the estimated program revenue produced by charging all beneficiaries with income over a $12,000 annual threshold a premium which would increase with each $4,000 of additional income up to a maximum of 10 percent of the estimated actuarial value of Part A benefits over the years 1984 to 1989 (for example, 10 percent of $147 monthly in 1984). It also shows the revenue increases resulting from imposition of a fixed-dollar Part A premium on all beneficiaries.

ACTION: The Board approved support for imposing some level of Part A premium on Medicare beneficiaries according to beneficiary income above a certain income level.

RATIONALE: The Board is in general accord with the concept of a Part A premium, but believes the concept might be accorded relatively low priority, in view of the small revenue increases produced and the lack — in contrast to use of coinsurance at the time of service — of any incentives to use services more prudently. The Board believes that varying the amount of premium according to beneficiary income above the threshold level is preferable to a fixed amount in that it would help avoid inequity for those of limited means.

PERTINENT AMA POLICY: The Association has no specific policy on a Part A premium or on an income-related Part A premium. However, Association opposition to the original Medicare program related in part to the fact that the program covered all elderly equally, regardless of income.

RECOMMENDATIONS OF OTHER GROUPS: As noted previously, the Advisory Council on Social Security opposes relating Part A premiums to beneficiary economic status, but supports use of a fixed premium, paid at the option of the beneficiary, to finance enhanced benefits under both Parts A and B. The Ways and Means Conference discussed a single income-related premium paid into a merged Part A/Part B trust fund, and suggested four methods by which it might be applied.

(b) Modified Part A coinsurance with cost-sharing limits: Medicare beneficiaries now run the risk of high out-of-pocket payments for long stays in the hospital due to severe illnesses. Under current law the Medicare benefits under Part A for inpatient hospital care beginning January 1, 1984, for each spell of illness, are: (1) $350 deductible for each stay; (2) no coinsurance for days 2 to 60; (3) 25 percent coinsurance for days 61 to 90 per benefit period; and (4) 60 lifetime reserve days with a 50 percent coinsurance rate. Currently Medicare beneficiaries are responsible for 100 percent of the hospital charges for all days after the 60 lifetime reserve days are used up. Imposing beneficiary coinsurance for certain hospital days beyond the first, up to a dollar maximum beyond which Part A would pay full hospital costs of whatever duration, could provide the coverage for catastrophic expenses now lacking under Part A, depending on the coinsurance and cost-sharing limits selected.

ACTION: The Board approved support for imposing beneficiary coinsurance for Part A hospital expenses up to a cost-sharing limit, with the cost-sharing amount varying according to beneficiary income status.

RATIONALE: Appendix A shows the trust fund savings possible from the coinsurance and cost-sharing limit combinations suggested by the Reagan Administration for fiscal year 1984 (an estimated $1.2 billion savings in 1985 and $3.2 billion in 1995). As with the use of a Part A premium, the initial savings generated by such coinsurance are relatively small in relation to total program revenue needs, particularly if cost-sharing limits are set so as not to preclude access to needed care. However, the more prudent utilization of services encouraged by this approach is desirable in itself and may also generate additional program savings. For these reasons, the Board believes that imposition of beneficiary coinsurance for Part A hospital expenses up to a cost-sharing limit should be supported.

The Reagan Administration in its Fiscal Year 1984 Budget request proposed a fixed cost-sharing limit for all beneficiaries, regardless of economic status. (This proposal is not part of the Fiscal

Year 85 Budget proposal.) The Board supports the concept of relating the cost-sharing limit to beneficiary income, and believes that cost-sharing limits might be varied according to multiple income levels.

PERTINENT AMA POLICY: Association policy supports the provision of catastrophic coverage for Medicare individuals with increased cost-sharing under Part A for hospital services. Association policy notes that cost-sharing should not generate revenue greater than necessary to provide catastrophic coverage.

RECOMMENDATIONS OF OTHER GROUPS: The Advisory Council on Social Security supports restructuring of Part A benefits to provide catastrophic protection (unlimited hospital inpatient days per year) and beneficiary coinsurance of 3 percent for all hospital days after the first. No cost-sharing limits based on income are proposed. The Ways and Means Conference discussed beneficiary coinsurance levels varying with the cost category (high, medium, low) of the provider used, coupled with cost-sharing limits based on beneficiary income.

(c) Raising the age of Medicare eligibility: Current law provides for incrementally increasing the age of eligibility for full Medicare benefits to 67 over the years 2005-2027. Savings generated by this step-up are generally acknowledged as having no immediate significant impact on depletion of the Part A trust fund. However, beginning the age step-up at an earlier date could generate significant additional program savings. Appendix A shows the estimated program savings resulting from increasing the age of eligibility at various rates, beginning with the year 1985.

> ACTION: The Board approved support for periodically increasing the age of eligibility for Medicare benefits beginning in 1985 or as soon thereafter as practical, to reflect changes in longevity, health and employment status, with special consideration given to coordinating eligibility dates for Medicare and Social Security cash benefits and to assuring continued private health insurance coverage for retirees until Medicare entitlement age.

RATIONALE: The Board believes that longer terms of employment, improved health status and longevity of the population amply justify raising the age of Medicare eligibility. However, because the step-up to age 67 beginning in 2005, already provided for by current law, will have no useful early impact on depletion of the Part A trust fund, the Board believes this step-up in eligibility age should begin as soon as possible. As indicated in Appendix A, an increase in eligibility age beginning in 1985 could save from $0.5 billion to $1.1 billion in that year and from $10.4 billion to $15.6 billion in 1995, depending on the speed and the extent of the increase in eligibility age.

Present laws prohibiting enforced retirement based on age prior to age 70, and the group health insurance policy conversion privileges increasingly being offered by employers will provide some protection for beneficiaries against a lapse in health insurance coverage due to an increased age of eligibility for Medicare. However, the Board believes it essential that special attention be given to ways of assuring health insurance coverage for retirees until they reach Medicare eligibility age, and to coordinating dates of eligibility for Medicare and Social Security benefits.

PERTINENT AMA POLICY: The Association has no specific policy on this proposal.

RECOMMENDATIONS OF OTHER GROUPS: The Advisory Council on Social Security supports increasing Medicare eligibility age to 67 by 3 and then 6-month increments from 1985 to 1990, and indexing the age of eligibility to changes in life expectancy thereafter. The Ways and Means Conference considered no proposals relative to increasing eligibility age.

(d) Increased Part B premium based on income: The Supplementary Medical Insurance (SMI) trust fund currently operates with a substantial infusion of dollars from general revenue. When the Medicare program was first developed, it was anticipated that the monthly Part B premium paid by beneficiaries would pay for approximately 50 percent of program costs. However, in 1982 premiums ($3.8 billion) equalled only 21.7 percent of total income, while general revenue contributions equalled over 78 percent of total income. Medicare law already requires an increase in the proportion of Part B costs paid by premiums to 25 percent by 1984, and the AMA has recommended that this proportion be increased to 35 percent. If distributed equally over the beneficiary population, the Part B premium increases called for could impose a financial hardship on some low-income beneficiaries.

> ACTION: The Board approved support for increasing the Part B premium to a level which funds 35 percent of Part B costs, with consideration given to relating the premium amount to income status of beneficiaries.

RATIONALE: While having no direct impact on income to the Hospital Insurance trust fund, an increase in Part B SMI premiums would reduce the amount of general revenue needed for the SMI fund, with beneficial effects on the federal treasury generally. The Board believes that relating the amount of premium to beneficiary economic status, with no increase imposed on those of more limited means, could help make other changes recommended in this report more acceptable to the groups affected. To minimize administrative complexity, premium differences could be related to no more than two or three different income categories.

PERTINENT AMA POLICY: The Association has no policy specifically on an income related Part B premium but does support increasing the Part B premium to cover 35 percent of program costs.

RECOMMENDATIONS OF OTHER GROUPS: The Advisory Council on Social Security does not recommend a general increase in Part B premiums, but does support an enhanced Part B benefit to be offered as an option to beneficiaries at an increased Part B premium. Participants at the Ways and Means Conference, as noted previously, proposed a single income-related premium for merged Part A and Part B coverage.

(3) SPECIAL PAYMENT ARRANGEMENTS FOR LOW-INCOME BENEFICIARIES

The Board considered a potential change in payments to physicians which would decrease costs to beneficiaries, namely, encouraging physicians to accept Medicare's "approved amount"* ("reasonable charge") as full payment for lower income beneficiaries.

Current AMA policy already encourages physicians to volunteer fee information to patients, and urges them to accept third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to patients through appropriate means their willingness to consider such arrangements.

> ACTION: The Board approved a continuation of policy that the AMA encourage physicians to accept Medicare's approved amount as full payment for those beneficiaries for whom additional payment would be a hardship. Such information should be made available by physicians to their patients and the local medical society. The decision to accept Medicare's approved amount should be made by physicians on an individual case-by-case basis, taking into account the individual's financial circumstances, rather than based on any specific income level.

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*Medicare's "approved amount" includes both the 80 percent paid by the program (after the beneficiary meets the initial Part B deductible) and the 20 percent coinsurance by the patient. Thus physicians accepting the "approved amount" as full payment would continue to bill beneficiaries for both the deductible amount and the 20 percent coinsurance.

RATIONALE. The Board believes that encouraging physicians to voluntarily declare, on a year-by-year basis, whether they would accept Medicare's approved amount as full payment for low income beneficiaries could also help facilitate acceptance of the other changes recommended in this report, by providing low-income beneficiaries the assurance of "full service benefits" for those financially in need of them.

Names of those physicians electing this option in each Medicare area would be compiled by the local medical society and beneficiaries could determine whether a given physician or physicians in their area had made that commitment through a call to the medical society. If it wished, the medical society could also make a list of such physicians available. The Board also believes that physicians agreeing to such assignment for low-income beneficiaries should be encouraged to communicate that fact to their present patients, through posting of appropriate office notices and patient information materials. As part of its proposals for restoring trust fund solvency, the AMA might prepare and make available to physicians sample announcements of this type.

The Board believes that the decision as to whether a beneficiary is of limited means should be made by physicians on an individual basis rather than based on any specific income level.

PERTINENT AMA POLICY: Present Association policy, in addition to encouraging physicians to make special payment arrangements in cases of economic hardship, also opposes differential payment for physicians accepting assignment, all-or-none assignment, and mandatory assignment under Medicare. This policy also expresses concern at the accuracy of and lack of complete information provided by lists showing the percentage of claims on which assignment is accepted by individual physicians.

RECOMMENDATIONS OF OTHER GROUPS: The Advisory Council on Social Security supports all-or-none assignment provisions under Medicare, with published lists of those physicians accepting assignment, and expedited billing incentives for such physicians. Participants at the Ways and Means Conference made no proposals with respect to physician assignment.

APPENDIX A

FISCAL IMPACT OF POSSIBLE CHANGES

Table 1 presents data on insured benefit payments and payroll taxes for Medicare Hospital Insurance Trust Fund for the years 1982 through 2005. These calculations indicate that for the next few years the difference between benefit payments and trust fund receipts will be small. However, by the year 1995 benefit payments will exceed trust fund tax receipts by $38.2 billion. A footnote on Table 1 describes the impact of the February 1984 CBO projections.

Various combinations of the proposals for increasing program revenue or reducing costs contained herein have the potential cumulative effect of more than offsetting this projected deficit at least through 1995. Displayed below are estimated revenue increases or cost savings which would result in selected years from implementing specific changes of a magnitude which the Board and the Councils believe are economically realistic and politically achievable. In most cases, 1985 and 1995 are the specific years selected; 1985 because it is the earliest year in which savings could realistically be expected, and 1995 because it is the latest year for which the data base allows reliable projections of the detailed proposals. Proportionate savings would of course also occur in the years between 1985 and 1995.

(Total dollar savings are not given because some changes are alternative approaches, e. g., numbers 3 and 4, or can be implemented at different levels, e. g., numbers 2, 5 and 6)

Change	Savings (in Billions)	
	1985	1995
1. 0.5 further combined increase (0.25 % to both employer and employee) in HI payroll tax rate, effective 1985	$ 9.0	$ 17.0
2. Increase in tax rate for both alcohol and tobacco products, effective in 1985, of:		
(a) 25%	$ 2.6	$ 5.1
(b) 50%	5.0	9.9
with additional revenue diverted to HI Trust Fund		
3. Progressive income – related Part A Premium up to 10 % of Part A actuarial value	$ 0.567	$ 0.677 (1989)
4. Fixed dollar Part A monthly premium of:		
(a) $ 5	$ 1.8	$ 2.2
(b) $10	3.7	4.3
5. Part A hospital cost coinsurance (as detailed in Reagan proposal*) with cost-sharing limit of:		
(a) $1,530 for all	$ 1.2	$ 3.2
(b) $1,530 for over $12,000 income beneficiaries and $765 for those under $12,000	1.0	2.6
6. Increase in Medicare eligibility age (beginning in 1985) to:		
(a) 67 by 3 months/year	$ 0.500	$ 10.4
(b) 67 by 6 months/year	1.100	10.4
(c) 68 by 3 months/year	0.500	14.2
(d) 68 by 6 months/year	1.100	15.6

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*The Reagan proposal of last year called for a maximum beneficiary out-of-pocket expenditure of $1,530 for covered hospital expenses, consisting of (a) the first day $350 deductible, (b) coinsurance of 8 percent of the $350 hospital deductible during days 2 through 15, and (c) coinsurance of 5 percent of the $350 hospital deductible for days 16 through 60. The beneficiary would have no further out-of-pocket spending for covered hospital services after the first 60 days of cost-sharing per calendar year.

TABLE 1*

MEDICARE HOSPITAL INSURANCE TRUST FUND

	Insured Benefit Payments (\$ billions)	Payroll Taxes (\$ billions)	Annual Difference (\$ billions)
1982 (actual)	35.2	34.6	– 0.6
1983	40.1	37.4	– 2.7
1984	45.1	43.1	– 2.0
1985	51.0	47.5	– 3.5
1986	57.2	55.8	– 1.4
1987	63.9	59.9	– 4.0
1988	71.1	64.1	– 7.0
1989	78.8	68.5	– 10.3
1990	85.5	71.8	– 13.7
1991	94.4	77.1	– 17.3
1992	104.0	81.8	– 22.2
1993	114.4	87.1	– 27.3
1994	125.6	92.5	– 33.1
1995	137.2	99.0	– 38.2
1996	150.1	105.3	– 44.8
1997	163.9	111.9	– 52.0
1998	178.8	119.1	– 59.7
1999	194.7	126.8	– 67.9
2000	212.1	135.3	– 76.8
2001	230.6	144.0	– 86.6
2002	250.6	153.2	– 97.4
2003	272.2	162.9	–109.3
2004	295.6	173.0	–122.6
2005	320.5	182.4	–138.1

Source: U. S. Department of Health and Human Services data and calculations by Center for Health Policy Research. Based on Alternative II-B.

*This table was prepared prior to the February 1984 CBO projections indicating some improvement in the financial status of the Part A fund. However, a likely result is only a temporary delay – perhaps only two years – in the rate of depletion of reserves implied by the above table.

APPENDIX B

REVIEW OF RECOMMENDATIONS OF ADVISORY COUNCIL ON SOCIAL SECURITY

The Advisory Council on Social Security has forwarded its report to the Secretary of the Department of Health and Human Services. The report consists of a series of recommendations that are likely to be utilized by the Secretary in formulating future legislative packages. The report will receive particular attention when the issue of the future solvency of the Medicare program is considered by both the Administration and Congress. In making its recommendations, the Advisory Council recognized the "likelihood of a $200–$300 billion deficit" in the Part A trust fund "by the year 1995." The Councils and the Board of Trustees reviewed the Advisory Council's recommendations and took the following actions concerning those recommendations.

1. General Revenue Contributions to the Hospital Insurance Trust Fund – The Advisory Council recommends opposition to any increase in the use of general revenues to finance the Medicare hospital (Part A) trust fund.

   ACTION: Support for Advisory Council's recommendation. However, as discussed later, certain tax money now directed to general revenue (alcohol and tobacco taxes) could be earmarked for the Part A trust fund.

2. Interfund Borrowing – The Advisory Council recommends that short-term interfund borrowing among the trust funds should be allowed when deemed necessary. Such borrowing should be subject to appropriate safeguards which include authority for each fund to borrow from the others, specific repayment schedules and prohibition against reducing the lending fund's assets below an actuarially acceptable level.

   ACTION: Support for Advisory Council's recommendation.

3. Taxation of Employer-Provided Health Insurance – The Advisory Council recommends passage of the Administration's proposal to tax employer's contributions to employee health benefit plans that exceed $70 a month for an individual and $175 a month for a family. The Advisory Council also recommends that a certain portion of the increased revenue should be earmarked for the Health Insurance (HI) Trust Fund.

   ACTION: Support for the Advisory Council's recommendation noting continuing AMA support of tax cap, but as incentive toward more prudent purchase of health insurance, not as a means to fund the Medicare program. Oppose earmarking.

4. Raising Revenues for the HI Trust Fund Through Increased Earmarked Federal Excise Tax and Alcohol and Tobacco Products – The Advisory Council recommends that the federal excise tax on alcohol and tobacco be increased with the increased revenue earmarked for the Medicare HI Trust Fund. (No specific saving figure was set, as the Advisory Council indicated that Congress should set the level of such excise taxes.)

   ACTION: Support the Advisory Council's recommendation.

5. Payroll Tax – The Advisory Council opposes any further increase in scheduled health insurance payroll taxes.

   ACTION: Oppose the Advisory Council's recommendation. The Board believes that some increase in the health insurance payroll tax is necessary. However, this increase should be considered as only a part of an integrated program to increase revenue and reduce expenditures, as appropriate, under the program.

6. Reallocation of Payroll Taxes Between OASDI and HI – The Advisory Council recommends that, if needed, consideration be given to reallocation of payroll tax rates between the OASDI and HI Trust Fund in order to transfer surplus in the OASDI trust fund to the HI Trust Fund from the period of 1985 through 1995.

   ACTION: Support in part the Advisory Council's recommendation. The Board supports reallocation by Congress while opposing granting the Secretary of Health and Human Services authority to make such reallocation.

7. Advance the Age of Eligibility for Medicare Benefits – The Advisory Council recommends increasing the age of eligibility for Medicare from age 65 to 67. The age of eligibility would be increased by three month increments per year starting in 1985, escalate to six month increments in 1989, with final implementation by January 1, 1990. Thereafter, the age of eligibility should be indexed to increases in life-expectancy.

   ACTION: Support the recommendation of the Advisory Council in concept. A mechanism is necessary to assure coverage during any period of time when a beneficiary would be eligible for Social Security cash benefits and ineligible for Medicare.

8. Diagnosis and Treatment-Related Coverage Under Medicare – The Advisory Council opposes further extension of Medicare coverage, by reason of medical diagnosis, to individuals not already eligible.

   ACTION: Support the recommendation of the Advisory Council.

9. Restructure of Medicare Part A Hospital Insurance and an Enhanced Part A Benefit Financed by an Annual Premium – This recommendation would provide for catastrophic care protection based on increased premiums. The use of premiums instead of increased cost-sharing as a financing mechanism would mean that all beneficiaries would share equally in the expense, instead of just those in need of care. The proposal consists of three parts as follows:

   (A) Restructure Medicare Part A hospital insurance to provide for unlimited hospital inpatient days per calendar year, a per admission deductible as currently computed (limited to two hospital admissions per calendar year), a daily coinsurance equal to 3 percent of the hospital inpatient deductible for all inpatient days after the first day, a skilled nursing benefit of 100 days per calendar year with no coinsurance on days 1-20 and a 12½ percent coinsurance on days 21-100, retention of the currently available home health benefits under Medicare Part A, and the current hospice benefit.

   ACTION: Support the Advisory Council's recommendation for coinsurance and catastrophic coverage in principle.

   (B) The Advisory Council also recommended an optional enhanced Part A insurance benefit to be financed by a Part A premium added to the Part B premium. The new premium would also include an additional base amount to provide additional revenues to reduce the projected Part A deficit. All beneficiaries who elect Medicare Part B coverage would be required to accept this enhanced benefit. The benefit would consist of elimination of the 3 percent daily coinsurance on hospital inpatient days and elimination of the coinsurance on days 21-100 in skilled nursing facilities.

> ACTION: Oppose the Advisory Council's recommendation, as competing with or duplicating coverage available from the private sector.

(C) The Advisory Council recommends a voluntary enhanced Part B benefit to be offered on an optional basis that would provide a $200 yearly stop-loss on Part B out-of-pocket expenses. This expanded benefit would be financed by an increase in the Part B premium. ($41 billion in program savings and additional revenue)

> ACTION: Oppose the Advisory Council's recommendation, for reasons given under 9(B) above.

10. Long-Term Care – The Advisory Council recommends that the HHS Secretary, in developing a comprehensive long-term care program, seek guidance from studies which have suggested targeting of groups that would benefit from those services.

> ACTION: Support the Advisory Council's recommendation.

11. Preventive Care Services – The Advisory Council recommends a comprehensive review of HCFA's demonstration projects to assess the economy and efficacy of expanding Medicare coverage to include preventive services to be undertaken prior to any change in the law.

> ACTION: Support the Advisory Council's recommendation.

12. Voluntary Vouchers – The Advisory Council recommends the use of voluntary vouchers in the Medicare program.

> ACTION: Oppose the Advisory Council's recommendation for full implementation of a voluntary voucher program. Support appropriate demonstrations of voucher programs prior to nationwide implementation.

13. Indexing Supplementary Medical-Insurance Deductible – The Advisory Council recommends that the current Part B deductible be indexed to the Consumer Price Index (CPI).

> ACTION: Support the Advisory Council's recommendation for indexing, but to the Medical Care Component of the CPI.

14. Prospective Payment – The Advisory Council recommends that the allowed increase for hospital costs under the DRG system (market-basket plus 1 percent for technology and intensity of services) should be modified to reduce the allowable 1 percent increase for technology and intensity.

> ACTION: Oppose the Advisory Council's recommendation. The new DRG system should not be modified before it is even fully implemented or evaluated.

15. Medicare Medical Education Expenses – The Advisory Council recommends that the cost of training medical personnel should not be borne by the Medicare program. The Advisory Council believes that such support should be sought through other sources.

    ACTION: Oppose the Advisory Council's recommendation, pending further review by Task Force of Councils on Legislation, Medical Education and Medical Service.

16. Medicare Reimbursement for Physician Services – The Advisory Council recommends elimination of the current usual-customary-reasonable formula. The Advisory Council recommends that as a step toward system reform the Medicare statute should be amended to authorize development of fee schedules, adjusted initially and periodically for differences in cost of living and/or maintaining a practice.

    ACTION: Defer action pending development of House of Delegates policy on this issue at the 1984 Annual Meeting.

17. Assignment of Medicare Benefits for Physician Services – The Advisory Council recommends that physicians be allowed to enter into participation agreements with the Medicare program whereby the physician would accept assignment for all services to Medicare patients. Those who did not enter into such agreement would be barred from accepting assignment for any claims. The Advisory Council also recommends that a directory be published listing the "participating physicians" and that expedited billing incentives be made available to such "participating physicians."

    ACTION: Oppose the Advisory Council's recommendation for all-or-none assignment option as being potentially harmful to beneficiaries, and oppose lists of "participating physicians" as misleading to beneficiaries. Expedited billing arrangements should be available to all physicians.

18. Medical Technology – The Advisory Council recommends that it should be a fundamental policy of the Department of Health and Human Services to promote the development of medical technology. In evaluating new technology, efficacy and cost should be considered.

    ACTION: Support the Advisory Council's recommendation.

19. "Advance Directives" or "Living Wills" – The Advisory Council recommends support for the concept of voluntarily advanced directives as a means of appropriate decision-making about life-sustaining treatment for incapacitated patients. The Advisory Council suggests that where states authorize living wills that they be offered to Medicare beneficiaries during sign-up for the program.

    ACTION: Oppose the Advisory Council's recommendation in principle. Living wills should be used for alleviating suffering and not linked to cost containment objectives.

20. Management of the Medicare Program – The Advisory Council recommends that HCFA continue its efforts to improve the management of the Medicare program.

    ACTION: Support the Advisory Council's recommendation.

21. Income-Related Premiums – The Advisory Council recommends opposition to any effort to tie entitlement to Medicare benefits to a beneficiary's financial status.

    ACTION: Oppose the Advisory Council's recommendation.

REPORT OF THE BOARD OF TRUSTEES

Report: O
(I-84)

Subject: Report on the Medicare Program: II

Presented by: John J. Coury, Jr., M.D., Chairman

Referred to: Reference Committee A
(Michael P. Levis, M.D., Chairman)

INTRODUCTION

As requested by the Board of Trustees, the Council on Legislation and the Council on Medical Service have continued to review the Medicare program for the purpose of recommending appropriate modification of Association policy concerning the program and the financing of health care for the elderly. In April 1984, the Councils developed and the Board approved a series of guidelines for the overall review of the Medicare program and a series of recommendations that, if adopted, would assure the solvency of the Medicare program through at least the next decade. Board of Trustees Report LL, based on the Councils' recommendations, was submitted to the House of Delegates and adopted at the 1984 Annual Meeting.

Report LL discussed the development of the Medicare program over the past quarter of a century. The report also reviewed the financial crisis facing the Medicare program--the fact that the Part A program was predicted to become bankrupt in the next decade--and identified the factors that are driving the program to insolvency. Report LL set out a series of proposals that AMA will use as a basis for Association action to assure the fiscal solvency of the Part A trust fund for at least the next decade. The report also indicated the Board's intention to continue analyzing the provision of health care services for the elderly and disabled, and the desirability and practicality of substantial further modifications to the Medicare program.

This report summarizes the results of the Board's analysis of the feasibility of an approach combining a modified Medicare program with private sector options to assure health care services for the elderly and disabled.

Past House Action: A-84:158-177

GUIDELINES FOR REVIEW OF THE MEDICARE PROGRAM

Report LL contained guidelines that were developed to provide a basis for the Board's review of available options concerning the Medicare program. As noted in Report LL, these guidelines impact on one another and they should, accordingly, not be evaluated individually but rather must be considered as a whole to determine whether proposals for programmatic modifications are appropriate. The guidelines are as follows:

1. Access to quality health care for the elderly and the totally disabled through Medicare should be assured. Responsibility for access should be shared by the federal government, the states (e.g., through Medicaid), providers, and beneficiaries.

2. The program should be on a fiscally sound basis to meet present and future needs in order to maintain access to quality care for Medicare beneficiaries.

3. All beneficiaries under Medicare should have access to the same range of program benefits, and should share in the program's cost in a way which encourages responsible use of medical resources. There should be a cost-sharing limit to protect the patient from catastrophic medical expense.

4. Medicare should provide payment for necessary medical services. It should be sufficiently flexible to make appropriate accommodations for new medical therapies and new technology. Expansion of benefits other than for medical services should not divert Medicare resources.

5. Medicare should assure freedom of choice of physician, provider, or system of health care delivery.

6. Medicare should encourage delivery of services in cost-effective settings consistent with appropriate quality of care.

7. Medicare should meet its obligation to pay its full share for promised benefits. Payment for services should be sufficient to assure reasonable access to those services. Physicians should consider accepting, as payment in full, the Medicare approved amount of charges* for those beneficiaries for whom additional payment would be a hardship.

8. Congress should periodically alter the age of eligibility to recognize changing trends in terms of employment, health status, and longevity of our citizens.

9. Medicare, along with other insurers and payors of medical care services--all of whom benefit from the medical education system--should continue to support medical education.

10. Medicare eligibility should not be expanded beyond the categories (aged, disabled, end stage renal disease currently recognized in the law.

11. Cost-sharing based on ability to pay may be considered when administratively feasible and necessary to ensure the fiscal integrity of the program.

In reviewing these guidelines, the Councils and the Board believe that they provide an appropriate and comprehensive framework for analysis of both short-term and long-term options relating to health care for the elderly. The Board envisions that substantial elements of a modified Medicare program would be retained as a framework for any proposed program of health care for the elderly.

BASIC POLICIES FOR MEDICARE REFORM

The Board believes that basic policy for long-term reform of the Medicare program should (a) assure access to quality health care services for program beneficiaries; (b) allow for a greater range of individual choices of potential options for participation in the modified Medicare program; and (c) assure the solvency of future programs. The Board and Councils believe that a program incorporating the best features of a modified Medicare program with new private sector approaches will appropriately meet the health care needs of the elderly and disabled for both the short term and long term.

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*"Approved amount" is synonymous with and replaces the term "reasonable charge" previously used by the Medicare program, and recognizes the beneficiary's obligation for coinsurance.

OPTIONS FOR MEDICARE REFORM

At the outset of their deliberations, the Councils considered and rejected three options:

Maintain the Medicare program with no change - With the projected future bankruptcy of the Hospital Insurance Trust Fund, this option was rejected by the Councils. The Board believes that it would be irresponsible for the Association to stand by without offering constructive alternatives to the existing program.

Terminate the Medicare program with no special provisions for the elderly and disabled - This option would have the effect of eliminating government's share of the responsibility for assuring access to health care for the elderly and the disabled. The Board was concerned that major gaps in services could develop for those individuals who would not be able to provide their own coverage.

Maintain the Medicare program with modifications in existing financing mechanisms, but with no change in benefits, payment mechanisms, or eligibility standards - While the Councils and the Board believe that there is a need to modify the financing mechanism for the Medicare program, they did not believe that simply increasing revenue into the existing system without any other changes would be adequate. With the projected increases in the population of potential Medicare beneficiaries, this approach was seen as being little more than a stop-gap measure that would fail to address fundamental problems in coverage and benefit structure or to meet the three goals set out above of long-term guarantees of access to quality care, choice, and solvency.

The Councils then addressed the following four additional broad policy alternatives concerning health care for the elderly and disabled, and selected the fourth as being most appropriate.

Replace the Medicare program entirely with tax incentives to encourage purchase of private insurance by the elderly and disabled, but continue federal and/or state financial assistance to the needy elderly and disabled - While the Councils found elements of this option attractive, they also identified some significant potential drawbacks.

Questions were raised concerning the willingness of the private insurance industry to market private coverage to the Medicare population and the potential for a substantial number of the elderly and disabled to fail to purchase private coverage, or to have to impoverish themselves to be eligible to receive government assistance for health care services. The Councils were also concerned that a lengthy transition period would exist where individuals would still have to devote substantial resources to cover existing obligations and to provide sufficient time for funds to be accumulated so that the elderly could purchase private coverage. Accordingly, the Councils and the Board rejected this option.

Replace the Medicare program entirely with a new combined federal-state program - While this option appears superficially attractive, the Councils noted that it would probably present many of the same types of problems experienced with the present Medicaid program. It was noted that there is a tremendous range in the availability of health care services under the existing state-federal Medicaid program. For example, 31 types of health care services are covered in one state (Minnesota), but only 7 types of health care services are covered in another state (Wyoming). Furthermore, states with large numbers of elderly could experience severe financial problems without assurances of adequate federal participation and safeguards. Accordingly, the Councils and the Board rejected this option as impractical.

Replace the Medicare program with a completely new federal program - The Councils gave serious consideration to discarding totally the existing Medicare program and starting again with a new federal program to finance health care services for the existing Medicare population. However, the Councils noted that any new federal program adopted by the Congress might be of a type--such as a government health service--that would severely limit access and choice (e.g., a government health service). Accordingly, the Councils and the Board also rejected this proposal.

Maintain a modified Medicare program with changes in benefits, payment methods, eligibility, and financing, integrated with private sector approaches - The Councils and the Board believe that this is the option which should be pursued at the present time. The Board also believes that fundamental modifications must be made in the above four major aspects of the Medicare program if its future is to be assured. In its Report LL (A-84), the Board has already recommended, and the House adopted, a number of modifications in these four elements. Such a modified Medicare program with private sector approaches has significant potential for assuring access to quality care for beneficiaries, and allowing these beneficiaries to seek the health care providers of their choice in meeting their health care needs. In addition, private sector approaches of the nature described in the next section could be combined with such a modified program.

FUTURE HEALTH CARE COVERAGE FOR THE ELDERLY AND DISABLED

In determining long-term proposals, the Board took note of the many changes rapidly occurring in the environment in which health care is being delivered. Fundamental changes in health benefit plan design, health delivery systems and reimbursement are occurring at a rapid rate, and recommendations concerning these broader changes are not at this time being proposed. Furthermore, pressures for mandatory assignment under the current program, and increased competition, will impact on any future programs. Also noted was the existence of separate basic coverage for the elderly, with widespread purchase of Medigap policies to provide extended coverage, including coverage for deductibles and coinsurance.

Based on their review, the Councils and the Board conclude that the most realistic approach to assuring health care coverage for the elderly and disabled is the development of an approach based on a modified Medicare program incorporating substantial changes in eligibility criteria, benefits, and financing mechanisms, combined with elements of private sector approaches. None of these private sector approaches in the Board's view constitutes a viable substitute for the current program in its entirety. However, the Board believes that elements of these approaches can be incorporated into a modified program of health care coverage for the elderly and disabled in such a way as to maximize private sector involvement in the provision of health care services for this population.

Medicare Modifications

To achieve this desired goal, the Medicare program would be restructured along the lines concurred in by the House of Delegates in adopting Report LL. These modifications would include:

1. A moderate one-time increase in the payroll tax rate on employers and employees;
2. An increase in the present tax rates for alcohol and tobacco products with the additional revenues from these new taxes directed to the Hospital Insurance Trust Fund;
3. Imposing the health insurance tax on the non-wage income of individuals on non-wage income above a certain threshold and up to the taxable maximum;
4. Imposing a Part A premium on Medicare beneficiaries based on beneficiary income that is above a certain level;
5. Imposing a coinsurance requirement on beneficiaries for Part A hospital expenses up to a specified cost-sharing limit, with the cost-sharing amount to vary according to beneficiary income status;
6. Periodically increasing the age of Medicare eligibility to reflect changes in longevity, health, and employment status, with special consideration given to the coordination of eligibility dates for Medicare and Social Security cash benefits, and to the assurance of mechanisms to continue private health insurance coverage for those who retire prior to attaining Medicare eligibility due to age; and
7. Increasing the Part B premium to a level adequate to fund 35% of program costs, with consideration to be given to relating the premium amount to the income status of beneficiaries.

While these modifications were proposed as "interim" proposals in Report LL, the Councils and the Board believe that such proposals can be structured to achieve desirable long-term results. For example, the proposals relating to means-testing and adjusting the eligibility age under the program could have significant long-term impact on the program over the foreseeable future.

Private Sector Approaches

- Health Individual Retirement Accounts (HIRA) - This concept would adapt the Individual Retirement Account concept into a savings program designed to generate a fund to be used for health care needs by eligible individuals, to supplement or supplant Medicare coverage. Such a program should include: incentives for investing in such an account; stipulations on the use of account funds and coordination of these accounts with Medicare benefits; transition provisions; ultimate disposition of unused funds.

  The Councils have met with proponents of "health individual retirement accounts" for discussion of specific proposals of this type. While details of the proposals vary, the general health IRA concept calls for workers to pay into private savings accounts. The funds contributed would generate a tax benefit (credit or deduction) at the time of contribution with tax deferred on interest earned over the life of the account. Upon a person's retirement, his health IRA funds could be used either to purchase private health insurance or to pay for medical care directly. For retirees with such health IRA accounts, the role of the federal government could be limited to providing catastrophic coverage based on ability to pay.

  The Councils and the Board view health IRAs as a promising long-term alternative for certain segments of the population. However, they recognize a number of problems which need to be addressed in this approach, including, an extended phase-in period to allow sufficient funds to accumulate; in a voluntary system, 100% participation would be unlikely; difficulty in predicting the amount of contributions needed to fund post-retirement health care expenses; and the burden of dual contributions for Medicare and health IRAs.

- *Vouchers* - A modified Medicare program could provide beneficiaries a voucher amount that could be used in tandem with other resources for health care.

  This voucher concept, based on the purchase of private insurance, offers certain additional positive features, including a predictable and controllable cost to the federal government; potential for beneficiary choice of practitioner or system; and increased efficiency through competition. In addition, the voucher would permit the beneficiary to purchase coverage integrating basic, supplemental, and catastrophic coverage with appropriate incentives for utilization.

  However, a free-standing voucher system is not without problems, the greatest of which may be adverse risk selection. Policies offering the highest benefits are most likely to attract beneficiaries with the greatest need for health care. This adverse risk selection would result in increased premiums above what would be expected from normal actuarial predictions. Thus, such a plan would no longer be competitive for reasons unrelated to programmatic efficiency. Beneficiaries selecting such coverage will bear a disproportionate premium burden relative to low-risk beneficiaries who elect less comprehensive coverage. Additional problems could include the cost of marketing health insurance plans; government oversight and potential regulation; private sector utilization controls on providers; and difficulty in development of voucher amount in light of variation in regional costs.

- *Employment-Based Health Insurance* - Under this concept, incentives could be developed to encourage employers to provide for *supplementary* health insurance coverage to retirees who are Medicare-eligible. Such coverage could be provided through corporate contributions to an Individual Health Retirement Account (IHRA), a health retirement funding program similar to corporate pension plans, or through inclusion of such coverage in the employment-based health insurance program. In situations where the employment-based health insurance program is utilized for a Medicare beneficiary, these benefits could be combined with the Medicare coverage in such a way as to allow companies to provide this coverage at the same cost as for younger employees, while at the same time offering a savings to the Medicare program.

Problems also exist in implementing this approach, including the disincentive for employing older workers, difficulties for small business, or gaps in coverage for employees due to bankruptcy, job changes, and unemployment.

CONCLUSION

The Councils and the Board of Trustees conclude that an appropriate mix of modifications in the current Medicare program with the combined selected private sector approaches of the nature discussed herein offer the best opportunity of assuring availability of health care services for the elderly and disabled over the long term.

Mr. FROST. I have several questions, Dr. Felts. I noticed your statement on page 5 calls for an across-the-board freeze on domestic and defense spending. You part company with the Reagan administration on this, in that the Reagan administration has consistently stated that they need an increase in defense spending of anywhere from 3 to 10 percent in a given year.

I assume that this is an intentional statement on your part that you are aware that the Reagan administration continues to press for year-to-year increases in the defense budget and that this is a significant parting of the ways from the administration?

Dr. FELTS. Your assumption is correct, sir.

Mr. FROST. I noticed also that your statement does not address something that the Reagan administration is likely to recommend next January and that this committee will have to pass on, and that is the question of physician DRG's I would appreciate hearing your comments about that.

Dr. FELTS. The reaction of the association to that concept, as you might predict, is very negative. Such a system would administratively be a nightmare in its complexity. The concept itself is essentially untried. We are aware that there are localized areas of experimentation that have been devoted to it, but most of these, to the best of our knowledge, have been based upon data bases that have assembled under past systems of charge data submitted and contain many of the inequities that have been perpetuated through the insurance system, so that the tested systems tend to perpetuate rather than correct many of those inequities.

There would be an incentive under such a system to not refer patients. There would be averages that would be assumed from one physician's patient population to that of another physician that are actually incorrect. When one thinks of the PPS and DRG's for hospitals that are really directed at some 5,000 or so hospitals, then tries to extend this to ambulatory care sectors with all the variations of specialty, subspecialty, patient illness, severity of illness, it really becomes almost unbelievable. I don't think averages can truly balance out from one physician to another. Each physician may not have a sufficient number of patients in each class to average out costs so that some physicians may be faced with severe shortages while others receive windfall reimbursements.

The incentives of such a system are weighted on the side of not providing care and I think that there could be even instances where a physician could no longer think of himself or herself as a true patient advocate as under our current situation.

I think there are many problems inherent to extending the DRG's to physicians.

Mr. FROST. Now, when the Acting Administrator of HCFA appeared before this task force several weeks ago, he indicated that this was under active consideration by the administration to be recommended as a part of their fiscal year 1987 budget. Has the AMA been in touch with the administration on this point? Does your organization feel the administration will recommend this for fiscal year 1987?

Dr. FELTS. The AMA has been in touch with HCFA pertaining to their considerations of changes in the physician reimbursement program. The concept of extending the DRG to physicians has been one of the issues that have been discussed. It is certainly one that we strongly oppose.

Mr. FROST. My question is, though, did you get the same indication that we got at the hearing we had that they may well recommend that for fiscal year 1987?

Dr. FELTS. We have had the impression that it is one of the "viable assumptions," which is being considered. But we have had indirect indications also that this was not at the top of their list of the possibilities.

The other things that are under consideration, of course, are fee schedules with the most desirable variation of that concept using a resource based relative value schedule [RVS]. HCFA has some contracts that have been let to study RVS and different variations in it, including the cost resource requirements, to provide certain specific services that would correct a number of inequities that have been and currently are in the present system.

I think if we had to give a preference with the limited knowledge we have at this time, we would prefer that over the DRG approach.

Mr. FROST. All right.

Mr. BLEHART. The AMA in conjunction with Harvard University, with AMA acting as a subcontractor, is in the process of studying a resource-based RVS under a grant from HCFA.

Mr. FROST. Interesting.

On another matter, page 2 of your testimony, you pointed out that over 69 percent of all Medicare claims now are accepted under assignment, although only 30 percent of physicians elected the participating status where they are obligated by law to submit all claims on an assigned basis. So, obviously, you have physicians picking and choosing which claims they would take under assignment, not taking all of them. Why is the number of participating physicians so low?

Dr. FELTS. I am not sure I can give you all-encompassing answers to that question. Physicians, by and large since the Medicare Program began, have been generally in support of the case-by-case determination, in fact the encounter-by-encounter determination, to allow them to provide free or reduced charges on services to individuals who have financial need, but to bill full fee for those who do not demonstrate such a need.

This has become pretty ingrained behavior, I suspect, in most of the Nation's physicians and they are very loath, I think, to abandon it.

Mr. **Frost**. It is my understanding—I am not sure whether it is the AARP or who but there are organizations that make available to their members lists of participating physicians in their geographic area so their members know which ones do accept all claims under assignment. What is the AMA's attitude about that? Have you all been cooperating with groups who prepare these lists so that senior citizens will know who the participating physicians are in their particular area?

Mr. **Blehart**. The lists are compiled by the Medicare carriers and the AMA has encouraged the State medical societies and the local and county medical societies to be helpful to individuals who call and ask questions about the lists. But the law requires that the information be made available specifically to senior citizens' organizations, Medicare carriers and Social Security offices. One of the problems actually is that if the local medical society asks for a copy of the lists so they can distribute information, they have to pay for that list. So some of the problems as far as the availability are actually incorporated right into the law creating the list.

Also the list, in and of itself, creates problems because it labels physicians as "participating" or "nonparticipating" and one of the semantic problems is that a physician labeled as "nonparticipating" certainly takes part and participates in the Medicare Program but doesn't necessarily take all claims on an assigned basis.

Mr. **Frost**. That is correct. When you say that there is a cost for the list, is it very substantial?

Mr. **Blehart**. I am not aware of what the cost is.

Mr. **Frost**. I think your testimony has been very helpful, and it may be that if the administration makes some sweeping new changes or proposals in their budget for fiscal year 1987 that this task force may want to give you the opportunity to come back next spring and to tell us some more about these proposals, because the indication that we got from the Acting Administrator of HCFA is something will happen in fiscal year 1987.

The Budget Committee will want to be sure we understand the implications of whatever is proposed. We will not just automatically accept a major change in the law or in the program just because the administration puts it in their fiscal year 1987 budget. We will certainly want to give you and other interested people the opportunity to be heard on that subject and to be heard at an early time before any action that we take would freeze that in place and really make it difficult for the substantive committees to have much leeway on the subject. So we would want to have you back and give you the opportunity to comment on that at that time. I would assume you would want to come back under those circumstances.

Dr. **Felts**. Yes; we thank you very much, Mr. Chairman. We certainly would like to avail ourselves of the opportunity.

Mr. **Frost**. All right. We have been pleased to have you here today. Thank you very much.

Dr. **Felts**. Thank you.

Mr. FROST. Our next witness is Alan Spielman, executive director of Government relations for the Blue Cross and Blue Shield Association.

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, ON BEHALF OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, ACCOMPANIED BY MICHAEL BROWN, DIRECTOR OF MEDICARE POLICY

Mr. SPIELMAN. Thank you, Mr. Chairman. With me today is Michael Brown, director of medicare policy for our association.

Under contracts with the HCFA, our association and member Blue Cross and Blue Shield plans perform intermediary and carrier services for Medicare, in effect administering the program on a day-to-day basis. We appreciate this opportunity to comment on the PPS and to discuss some proposals for future changes. We applaud your task force's interest in this important area.

Before commenting on these issues, we would like to review the history and current status of the program's implementation.

As you know, PPS was the most significant change in Medicare payment policy since the program's beginning. Yet both the enactment of the legislation and the system's implementation were accomplished at an extraordinarily rapid pace. From the date of enactment to the law's effective date in October 1983, HCFA and Medicare intermediaries were faced with a monumental task and responded well to this task. At this point, all hospitals subject to PPS have completed at least 1 year under the new system and some have completed more.

However—and this is key—the cost reports for hospitals fully under PPS were not due until recently and audits of these reports have not yet been completed.

Also, while all hospitals subject to PPS have now phased into the system, it is important to note a key feature of PPS, national pricing, has not yet been fully implemented. The hospital's own base year costs still account for 50 percent of its prospective payments. For these reasons, we believe it is not yet possible to assess the full effect of PPS on beneficiaries and providers.

It certainly is reasonable to assume that the PPS incentives have contributed to the dramatic reductions in hospital utilization that we have seen, but surely other factors such as innovative benefit design and management by private payors have also played a role. We have seen many positive steps being taken by hospitals to become more cost efficient. We are concerned, however, as the task force is, about the potential that the PPS financial incentives may have on access to needed hospital care and quality of care.

While there has been recent anecdotal evidence of beneficiaries being discharged prematurely, we believe, frankly, it is too early to reach even tentative conclusions about the effect of PPS on quality of care. We urge you not to rely on anecdotal information but to defer until a thorough evaluation can be accomplished to then identify a true basis for conducting further policymaking.

We look forward to HCFA's forthcoming report on the impact of PPS. We note that PPS was intended to increase the use of nonhospital services such as skilled nursing facilities and home health care. It is not surprising to hear reports of more severely ill beneficiaries being treated in these settings. This points out to us the need for increased attention to intermediary activities relating to these services.

Medical and utilization review of all covered services has received greater attention in recent years in part as a result of the growing awareness that total expenditures are a function not only of the price or rate paid for the service, but also the number and types of services that are rendered. In our private business, we have in fact found that changing the patterns of health care utilization has been a major factor in our success in containing health benefits cost. This points out the critical importance of comprehensive administration of the Medicare Program. Each Medicare intermediary has been responsible for the administrative activities relating to all covered services under part A of the program.

Recently, however, there has been a move toward specializing intermediary functions by type of provider. Last year Congress directed HCFA to reduce the number of intermediaries dealing with home health agencies to no more than 10, and although that provision has not yet been implemented, there is a proposal in the Senate's budget reconciliation bill that would reduce the number of intermediaries for skilled nursing facilities, in effect regionalizing this critical function.

We oppose these moves. We believe that having one entity administering hospital benefits, a second dealing with skilled nursing facility benefits and a third possibly dealing with home health benefits—the list can go on and on by bringing in hospices and other providers—is not in the best interests of the Medicare Program or its beneficiaries. In addition, comprehensive administration has an additional advantage under the program as you look toward further refinements to PPS and other reforms such as capitation.

Mr. FROST. Let me ask you at this point. You state in the introduction here, in your written statement, that Blue Cross and Blue Shield processes 85 percent of all Medicare part A bills including nearly all hospital bills and 62 percent of part B claims. Why would it be a problem if the number of intermediaries administering the home health care were limited to no more than 10? Presumably you would be one of the 10. I don't understand why it would cause a problem.

Mr. SPIELMAN. My comment is not directed at who would administer it but really the site and locus of that administration. We believe that having the review agency as close as possible to the site where services are provided and dealing with the beneficiaries at that level is really the best approach to administration.

I think one of the things we don't know, for example, is what effect on beneficiaries and program costs the regionalization of home health will have. I think it is not a question of whether or not Blue Cross and Blue Shield would administer the program but whether it is in the long-term best interests of the program. Again, we think when you get to reviewing care, of course, it is important to look at the continuum of care, and we believe you are in a better position to do that if you have a more comprehensive responsibility.

Mr. FROST. Fine. Proceed.

Mr. SPIELMAN. Another administrative issue relating to PPS is that the new system was put in place and is now being administered at a time when numerous other changes were made in Medicare. All of these changes have come in an environment of severe restrictions in the administrative funds available for intermediary and carrier activities, and predictably these changes, funding restrictions and, recent, unexpected increases in claims volume, has resulted in some problems. We have seen that the ability of intermediaries to maintain the timely processing of hospital bills has been reduced.

Thus, while the implementation of PPS has been surprisingly successful so far, the combined effect of several factors has resulted in some problems. We believe that the success of future legislative refinements to PPS and other needed changes in Medicare will depend in large part on having a stable administrative structure with adequate capacity to implement them with a minimum of disruption to both beneficiaries and providers.

Looking ahead, we believe that there are a number of refinements that should be made to PPS to increase the accuracy, equity and effectiveness of the system. Let me outline them briefly. Specifically, a measure of severity of illness should be incorporated into the system as soon as possible.

In addition, the refined wage index should be implemented and implemented prospectively, in our view.

An adjustment for disproportionate share hospitals should be made, and the adjustment for indirect cost of medical education should be reviewed. Efforts are, as you know, underway in the Congress and the administration to address these issues.

Mr. FROST. If I could interrupt you at this point. When you say reviewed, what do you mean?

Mr. SPIELMAN. Well, Mr. Chairman, part of the intent of the indirect adjustment was to cover some of the costs that some researchers have suggested are picked up by a disproportionate share adjustment, should one be made. Both the House and Senate reconciliation bills include disproportionate share adjustments and changes in the indirect medical education adjustment. My point is that we should look at these adjustments together and see if the disproportionate share adjustment might warrant some adjustment to that indirect factor.

Mr. FROST. Some adjustment downward?

Mr. SPIELMAN. Conceivably.

Mr. FROST. We had some testimony on this at one of our hearings.

Mr. SPIELMAN. The point I make is you have to look at the two in tandem. I am not suggesting what the adjustment might be.

Mr. FROST. But there is a degree of overlap between the two of those when they would both be in place?

Mr. SPIELMAN. Yes.

In addition to refinements to the PPS system as now structured, new approaches to payments for the passthrough costs of capital and medical education are needed.

Regarding capital, we believe capital should be incorporated into the PPS rates, provided a reasonable transition period is provided. We look forward to the upcoming report of HHS on this subject.

Regarding medical education, we believe private payors and Medicare both need to reexamine present reimbursment policy. We generally support proposals such as Senator Durenberger's now in the Senate budget reconciliation bill which would limit Medicare reimbursement and medical education to the time it takes for a resident to become board eligible or 5 years, whichever is less. We are currently examining our policy regarding payments for medical education in our private business.

I should stress that efforts to reform reimbursement for medical education should be accompanied by an examination of the willingness and capacity of other financing sources to contribute to the cost of training needed health professionals.

We also believe that major efforts should be placed on monitoring PPS. There clearly is a critical need to monitor quality of care. Also important is the need to monitor hospital financial operations through audits of cost reports. Audits not only return savings on the hospital services that continue to be paid on a passthrough reasonable cost basis, but they also provide an objective basis for determining how the hospitals are faring under PPS. In addition, should a decision be made to rebase PPS rates, audited cost data will be invaluable.

Thus Congress may wish to consider retaining the requirement for hospital cost reports after its scheduled elimination.

Clearly, the full implementation and expansion of PPS will enable HCFA to consider variations to the current cost reporting forms and auditing activities, and we hope to assist in efforts to make these processes more effective and less burdensome on providers.

Another critical area to be addressed, as you mentioned with the prior witness, is reforming Medicare reimbursement for physician services. Physician payment on a per case basis, possibly using DRG's in some way, is conceptually appealing. However, several technical obstacles would have to be overcome and a number of fundamental policy questions would have to be resolved in order for this to be put in place. In the short term, we believe fee schedules for Medicare would be more realistic. We would note that a fee schedule would not by itself address concerns about spending growth in the Medicare part B program.

As you look to payment——

Mr. FROST. Excuse me, if I may. It may just change the way reimbursement is made, but it may not affect savings; is that what you are saying?

Mr. SPIELMAN. Yes. The critical point, as my testimony indicates, is that at least conceptually, it doesn't address utilization, and that is a key factor in explaining the growth of part B expenditures. While you might have price restraint you might not have overall cost containment.

Mr. FROST. How do you address the utilization question? You can't stop people from being sick, you can't stop them from seeing a physician.

Mr. SPIELMAN. From our perspective, this reinforces the need for adequate efforts for medical review and utilization review by part B carriers. Clearly, there is a question of monitoring the system, and obviously quality of care needs to be assessed. As you say, people do get sick.

What we would want to guard against, however, is seeing utilization increases that are generated primarily or solely by restraints in prices. I think some of the historical experience with price controls suggest that that tended to happen. So I think it is important to have the medical review and utilization review in place.

Mr. FROST. Would that argue in favor of a DRG concept which would provide the physician with *x* amount of money for treating this patient regardless of how many times he or she sees the patient rather than some sort of fee schedule that might be based on a per-visit basis?

Mr. SPIELMAN. Conceptually it does to some extent, but I would not underestimate the importance of some of these policy questions that I have identified. Clearly payment on a per-case basis, depending on how you define your case, addresses to some extent the utilization question. It doesn't obviate the need for the review. I think you need to balance that objective with some of the other concerns.

In our view, we don't really feel there is enough information now in some of these areas to enable you to go that route first and it may well be that further research and even experimentation could provide the basis for a transition to some limited alternative approach later.

Mr. FROST. So you are suggesting that we shouldn't do this lightly?

Mr. SPIELMAN. Yes.

Mr. FROST. We better be careful if we decide to go in this direction?

Mr. SPIELMAN. Yes, sir.

Mr. FROST. OK. Proceed.

Mr. SPIELMAN. As you look to payment reform under Medicare, you may wish to consider innovations of Blue Cross and Blue Shield plans. In our business, we use a variety of payment and utilization management approaches to provide flexibility and be responsive to local conditions. Capitation through HMO's is one approach being used by Blue Cross and Blue Shield plans and Medicare. However, many beneficiaries have no access to HMO's or do not wish to change physicians. Thus, some of our plans are exploring with HCFA an approach called carrier or intermediary capitation on an experimental basis. Under this approach, beneficiaries would be provided a choice of benefit packages and the contractor would be responsible for managing the total cost of care.

In conclusion, we believe that——

Mr. FROST. You know, I am interested in this. I saw it in your testimony. What you are saying is you would be such a big group that you would negotiate with individual physicians regarding their fees and Blue Cross would be in effect a giant HMO in the area? Do I misunderstand what you are saying?

Mr. SPIELMAN. To some extent, that is correct. Surely negotiations with certain large groups of providers would be part of it. One possible approach is to build upon existing private sector mechanisms we have developed. For example, one approach involves PPO's, or preferred provider organizations, where an identification is made of which physicians and hospitals are the most cost effective. Rather than restricting choice to those providers, financial incentives are offered for people to use them. Conceivably Medicare could be piggybacked on that approach to provide greater management of the total benefit while not restricting access to only certain physicians. With this approach the analogy to HMO only goes so far because you would not be locked into a certain panel of physicians.

Mr. **Frost**. So under this carrier capitation program, the patient could still go to the physician of his choice. Is that what you are saying?

Mr. **Spielman**. Yes; depending on what particular option they selected. Again this is more concept than design and there are Blue Cross and Blue Shield plans engaged in talking about precisely these details, exactly how it would work. But one concept discussed would be to provide three options: A full choice option, an option of using a PPO panel and even a HMO panel option. Clearly under any approach HMO's and comprehensive medical plans would be permitted and encouraged to expand their enrollment.

Mr. **Frost**. The sentence in your testimony I find interesting is the contractor could negotiate prices with providers.

I think if you were a giant HMO, you would certainly have a big stick in a particular area.

Mr. **Spielman**. Yes; and in our private business with hospital reimbursement essentially, that is how we do business. However, when you get into the individual practitioner level, it is much more complex. There you are looking at the possibility of large multispecialty groups being potentially a source for negotiating prices.

Mr. **Frost**. It would be interesting. Please continue.

Mr. **Spielman**. In conclusion, we believe that the implementation of PPS so far has been successful although some administrative problems have emerged as a result of the many changes that have occurred in Medicare and restrictions in administrative funding.

Based on our experience thus far, we believe that a stable administrative structure, clear objectives, adequate leadtime, and appropriate funding are necessary conditions to assure effective implementation of refinements to PPS and any expansion of prospective payment. These conditions are especially necessary to assure continued support from beneficiaries and providers.

As we have noted, the effect of the system itself on beneficiaries and providers is not yet clear. Monitoring the effects of PPS is a critically important activity and while some fine tuning will be in order, we urge you not to act hastily based on anecdotal reports.

Revising the payment method for physicians' services is another needed reform, but fee schedules appear to be more feasible than per case payments in the short term.

Comprehensive administration of the program, rather than fragmented specialized administration, has the greatest potential to assure that Medicare payments are made properly and is consistent with the expansion of PPS and other innovative approaches such as carrier capitation.

Blue Cross and Blue Shield plans are firmly committed to the success of PPS in assuring quality care at a reasonable cost to the Medicare trust fund. We would be glad to work with the task force as you pursue this issue in the months and years ahead.

Thank you.

[Testimony resumes on p. 319.]

[The prepared statement of Mr. Spielman follows:]

PREPARED STATEMENT OF ALAN P. SPIELMAN

Mr. Chairman and Members of the Task Force, I am Alan P. Spielman, Executive Director of Government Relations for the Blue Cross and Blue Shield Association, the national coordinating organization for all of the Blue Cross and Blue Shield Plans. Today, our Plans underwrite or administer health care coverage for 100 million Americans, including more than 20 million Medicare beneficiaries. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for the day-to-day administration of this important program. We process 85% of all Medicare Part A bills, including nearly all hospital bills, and 62% of Part B claims. We also are the largest underwriter of Medicare supplemental coverage. In addition, Blue Cross and Blue Shield Plans have developed and implemented numerous innovative payment methods for hospital and physicians' services over the years.

We appreciate the opportunity to comment on the current Medicare Prospective Payment System (PPS) for hospitals and proposals for future changes in Medicare payments to both hospitals and physicians. We applaud the Task Force's interest in an area that has been the subject of much debate as Congress strives to meet its budgetary objectives. Before commenting on the effects of PPS, we would like to review briefly the history and current status of its implementation.

PPS Implementation

PPS is the most significant change in Medicare payment methods since the program began. Yet both the enactment of the legislation authorizing PPS and the system's implementation were accomplished at an extraordinarily rapid pace. The PPS proposal was included in an HHS report to the Congress in late December, 1982. Shortly thereafter it was quickly introduced as legislation, and enacted in April 1983, with an effective date of October 1, 1983. With such a short initial implementation period, HCFA and Medicare intermediaries were faced with a monumental task of immense complexity.

During that short period, an entire body of regulations was developed, instructions were issued to the intermediaries, intermediary computer systems were changed and beneficiaries and providers were educated on the new system. In addition, it was necessary for the intermediaries to conduct base year audits of each provider converted to the new system. The base year audit required that an onsite audit be performed on each hospital to establish the hospital-specific portion of the new payment system. Because hospitals were phased into PPS according to their fiscal years, activities relating to base year audits continued through September 1984.

At this point, all hospitals subject to PPS have completed at least one year under the new system. Some have completed two years and others are into the third year. However, the cost reports for hospitals fully under PPS were not due until August 1985. Audits of these first cost reports have just begun and a significant number have not yet been completed. Moreover, the audits that have been completed generally relate to smaller hospitals, and thus are not representative of the universe of hospitals subject to PPS.

While all hospitals subject to PPS now have phased into the new system, it is important to note that a fundamental feature of the system — national pricing — still is not in place. A hospital's own base year costs still account for half of the basis of its prospective payments.

Effects of PPS

For a number of reasons, including the lack of audited cost data and the fact that the transition to national PPS rates is not yet complete, it is not possible yet to assess the full effect of PPS. It certainly is reasonable to assume that the PPS incentives have contributed to the dramatic reductions in hospital utilization that we have seen. However, increased cost-consciousness among employers and insurers, innovative health benefit design and management by private payers, and changing attitudes of our population towards medical care also have played a role. For example, from our perspective, both as a Medicare intermediary and as a major source of private coverage for hospital care, we have seen positive steps being taken by hospitals to become more efficient.

We are concerned, however, about the potential negative effects that the PPS financial incentives may have on access to needed hospital care and the quality of care. While there has been recent anecdotal evidence of beneficiaries being discharged from hospitals prematurely, we believe that it is too early to reach even tentative conclusions about the effect of PPS on quality of care. We believe that relying on these anecdotes, rather than thorough evaluation, would create an inherent risk of premature and imprudent policy-making. We are not aware that any significant number of the millions of PPS admissions and discharges have been reported to be inappropriate. We cannot conclude, however, that there is no quality problem. We believe that HCFA's forthcoming report on PPS may provide valuable data on the quality issue.

We also would note that PPS is intended to increase use of skilled nursing facility care and home health care where appropriate. Anecdotal reports of more severely ill beneficiaries being treated in non-hospital settings are not surprising. The role of nursing homes and home health agencies is becoming more important as a result of the incentives established by PPS. Consequently, we believe that increased attention to intermediary activities related to reimbursement, audit, and utilization review of services furnished by these providers is appropriate.

Concerns have been raised that the potential increase in demand for SNF and HHA services, coupled with an increasing focus on the cost-effectiveness of intermediary medical and utilization review activities, may act to restrict beneficiary access to the care to which they are entitled. We do not believe this to be true. There are many checks and balances in HCFA's review system that work to prevent such a situation. For example, while intermediaries are evaluated by HCFA on the cost effectiveness of their MR and UR activities, they also are evaluated on the accuracy of their coverage determinations. There are no "quotas" for denials, as some have suggested.

Medical and utilization review of all covered services has properly received greater attention in recent years as a result of the growing awareness that total health care costs are a product of both the price and the number and type of services rendered. Indeed, in our private business, focusing on changing the patterns of health care utilization has been a major factor in our success in containing health benefits costs. Since PPS, by itself, does not incorporate explicit utilization control measures and, in fact, provides incentives to admit less sick patients, greater emphasis on reviewing the medical necessity and appropriateness of hospital admissions is justified. Similarly, since PPS only covers inpatient hospital care, the role of intermediaries and carriers in monitoring and controlling on the broad range of services and providers not covered now by PPS — SNF, HHA, hospital outpatient, and other Part B services — becomes even more critical.

The increased attention to skilled nursing and home health services as a result of PPS also points out the critical importance of comprehensive administration of the Medicare program. Traditionally each Medicare intermediary has been responsible for the administrative functions for all covered services under Part A of the program. We believe this approach is fundamentally sound. Recently, however, there has been a move towards specializing intermediary functions by type of provider. Last year Congress directed HCFA to reduce the number of intermediaries administering the home health benefit to no more than 10. Although that provision has not yet been implemented, there is a proposal included in the Senate's Medicare budget reconciliation bill that would similarly reduce the number of intermediaries administering the SNF benefit — in effect, regionalizing this critical function. We oppose these moves because we believe that having one entity administering hospital benefits, a second dealing with skilled nursing facility services and a third dealing with home health care for the same area is not in the best interests of the Medicare program or its beneficiaries.

The debate about the effects of PPS on alternatives to inpatient hospital care underscores the critical point that health care delivery is a continuum and that efforts to manage health care costs must focus on total Medicare benefit expenditures in order for them to be effective. To manage the health benefits "bottom line" most effectively for employers' private coverage or for HCFA regarding Medicare, Blue Cross and Blue Shield Plans need expertise in, information on, and responsibility for a comprehensive array of covered benefits. Moreover, comprehensive administration has additional advantages as Medicare increasingly looks to expansion of prospective payment to other services as well as to capitation or other managed care approaches.

Administrative Issues Relating to PPS

A significant factor relating to the implementation of PPS is that the new system was put in place, and is now being administered, at a time when numerous other programmatic and administrative changes were taking place in Medicare. Since 1983, Medicare intermediaries and carriers have had to respond to at least 50 significant changes, including the implementation of a uniform provider billing form, secondary payer initiatives, the physician fee freeze, and major changes in clinical laboratory and durable medical equipment reimbursement.

All of these changes — which have added to administrative complexity at least in the short run — have come in an environment of severe restrictions in the funds available for intermediary and carrier activities. Predictably, the plethora of changes, funding restrictions, and recently, unexpected increases in bill/claims volume have resulted in some problems. For example, the ability of intermediaries to maintain timely processing of hospital bills has been reduced. From April 1984 to April 1985, the number of hospital bills pending over 30 days increased by 250 percent. This problem has been brought to the attention of the appropriations committees which have jurisdiction over Medicare administrative activities. Also, because HCFA has had to respond to so many complex program changes, the issuance of revised cost reporting forms was delayed despite the agency's dedicated and concerted efforts. As a result of this delay and other pressures, the normal cycle of cost reporting, auditing, and settlement has been disrupted.

Thus, while the implementation of PPS so far has been surprisingly successful in view of the tremendous tasks involved and the short time frames available, the combined effect of several factors that characterize the current environment has resulted in some problems. We believe the success of future legislative refinements to PPS and other needed changes in Medicare will depend in large part on having a stable administrative structure with adequate capacity to implement them with a minimum of disruption and confusion to beneficiaries and providers.

Considerations for Future Change

We believe that there are a number of refinements that should be made to PPS to increase the accuracy, equity and effectiveness of the system. Such refinements would provide a reasonable assurance that the "winners" and "losers" under the constrained payment system reflect true differences in efficiency, and are not simply the result of imbalances in the system.

Specifically, a measure of severity of illness should be incorporated into the system as soon as possible. In addition, a refined wage index should be implemented prospectively, an adjustment for "disproportionate share" hospitals should be made, and the adjustment for the indirect costs of medical education should be reviewed. Efforts are underway in the Congress and in the Administration to address these issues.

In addition to refinements to the PPS system as it is now structured, new approaches to payment for the "pass-through" costs of capital and medical education are needed. With respect to capital, we do believe that a capital allowance can and should be incorporated into the PPS rates, provided that a reasonable transition period is provided. We look forward to the upcoming report of the Department of HHS on this important subject.

Regarding the direct costs of medical education, we believe that both Medicare and private payers need to reexamine present reimbursement policies. Physician supply is increasing rapidly, particularly in certain subspecialties, and the increased cost-consciousness of purchasers of care raises serious questions about appropriateness of financing such a large share of the costs of training physicians through the rates charged to patients. We generally support proposals such as Senator Durenberger's, incorporated in S. 1730, the Senate Budget Reconciliation bill, which would limit Medicare reimbursement for medical education to the time it takes for a resident to become board-eligible or 5 years, whichever is less. We are currently examining our policy regarding payment for medical education for our private business. Efforts to reform reimbursement practices for medical education should, however, be accompanied by an examination of the willingness and capacity of other financing sources to contribute to the costs of training needed health professionals.

In addition to making refinements to improve the PPS system and addressing the costs of capital and medical education, we believe that major efforts should be devoted to monitoring PPS, both to provide empirical evidence on the effects of the system on beneficiaries, providers and Medicare costs and to provide the information needed to improve the system. Even anecdotal evidence on premature discharges and the increasing severity of cases treated by SNF's and HHA's underscores the critical need to monitor quality of care, although we would note that confirmation that these providers are treating sicker patients would not by itself indicate that a quality problem exists. Also of critical importance is the need to monitor hospital financial operations through audits of cost reports. Audits not only return savings on those hospital services that continue to be paid for on a reasonable cost basis, but they also provide an objective basis for determining how PPS hospitals are faring. In addition, should a decision be made to rebase PPS rates, audit data would be invaluable. Thus, Congress may wish to consider retaining the requirement for hospital cost reports after its scheduled elimination beginning in Fiscal 1987. Clearly, the full implementation and expansion of PPS will enable HCFA to consider variations to the current cost reporting forms and auditing activities, and we hope to assist in any efforts to make this process more effective and less burdensome on providers.

Another critical area to be addressed is reforming Medicare reimbursement methods for physicians' services. Physician payment on a per case basis, possibly utilizing DRGs in some way, is conceptually appealing. However, several technical obstacles would have to be overcome and a number of fundamental policy questions would have to be resolved, including those relating to the assignment of Medicare claims and the appropriate entity to receive the payments. We believe that in the short term, fee schedules for Medicare would be more realistic. Fee schedules could be developed based on existing charge patterns or a relative value scale. In addition, flexibility could be provided for adjustments and possibly alternative approaches at the local level. We would note, however, that a fee schedule would not, by itself, address concerns about spending growth in the Medicare Part B program. In particular, a fee schedule concept does not address the control of utilization, which is a key factor explaining the growth of Medicare Part B expenditures for physicians' services.

As you look at payment reform for physicians, hospitals and other providers under Medicare, you may wish to consider the innovations of private payers such as Blue Cross and Blue Shield Plans. In our private business, we use a variety of payment and utilization management approaches, providing the flexibility to respond to local conditions within the overall framework of competition. We are convinced that competition, rather than rigid regulatory approaches such as rate-setting, is most effective in containing health care costs.

Capitation, through HMOs and CMPs, is an approach already being used by Blue Cross and Blue Shield Plans and by Medicare. However, many beneficiaries have no access to HMOs or do not wish to change physicians. Thus, some Plans are exploring with HCFA an approach called carrier capitation. Under this approach, a Medicare carrier or intermediary would receive a capitated amount per beneficiary, and all beneficiaries in a particular geographic area would be included except those enrolled in HMOs and CMPs. The contractor could negotiate prices with providers. Beneficiaries could choose to continue to receive the current Medicare benefit package from their usual providers, or they could elect to receive enhanced benefits from a list of providers selected by the contractor based on quality and price.

Conclusion

In conclusion, we believe that the implementation of PPS so far has been successful, although some administrative problems have emerged as a result of the multiplicity of changes that have occurred in Medicare and restrictions in administrative funds. Based on our experience thus far, we believe that a stable administrative structure, clear objectives, adequate lead time, and appropriate funding are necessary conditions to assure the effective implementation of refinements to PPS and any expansion of prospective payment. These conditions are especially necessary to assure continued support from beneficiaries and providers.

As we have noted, the effect of the system itself on beneficiaries and providers is not yet clear. Monitoring the effects of PPS is a critically important activity and while some fine-tuning undoubtably will be in order, we urge Congress not to act hastily based on anecdotal reports.

Revising the payment method for physicians' services is another needed reform, but fee schedules appear to be more feasible than per case payments in the short term.

Comprehensive administration of the program, rather than fragmented specialized administration, has the greatest potential to assure that Medicare payments are made properly, and is consistent with expansion of prospective payment and other innovative approaches such as carrier capitation.

Blue Cross and Blue Shield Plans are firmly committed to the success of PPS in assuring quality care at reasonable cost to the Medicare trust fund. We would be glad to work with the Task Force as you pursue this important area.

Mr. FROST. Thank you.

I find that to be interesting testimony and there are a number of issues that the Budget Committee will be dealing with in the health area next year and depending on how sweeping the administration's recommendations are, there may be a great deal of action in this area.

As appropriate, we will invite people to come back and tell us what they think.

Mr. SPIELMAN. Thank you, Mr. Chairman. We would appreciate that opportunity.

Mr. FROST. Next we have a panel of three individuals: Paul Willging, Ph.D., executive vice president, American Health Care Association; Margaret Cushman, M.S.N., R.N., executive vice president, Visiting Nurses and Home Care, Inc.; and Mary Fisher, M.S.N., B.S.N., American Nurses' Association.

I would ask each one of these witnesses to summarize their statements. The entire statements will be entered into the record, of course.

I would mention to Ms. Cushman that prior to being elected to Congress in 1978, I served on the board of the Dallas Visiting Nurses' Association for several years and I am familiar with what they do, at least in my community.

So, Mr. Willging, if you will proceed.

STATEMENT OF PAUL R. WILLGING PH.D., EXECUTIVE VICE PRESIDENT, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. Thank you, Mr. Chairman.

I appreciate this opportunity to represent the American Health Care Association before this task force. We represent 9,000 nursing homes in the United States and it is therefore the largest trade association representing nursing homes. We have a critical interest in the PPS system, Mr. Chairman.

Our view is that the PPS system for hospitals does work and the Medicare system, to some extent because of the success of the PPS system, does not work. By not working, I mean essentially the continuum across the part A benefit within Medicare. The equation, frankly, is not balanced. If anything, the PPS system will put that system into further imbalance.

Several studies have already shown that the PPS is responsible for patients being discharged from hospitals sicker and quicker than before the DRG system., Increasingly, however, they are finding they have no place to go.

Frankly, Mr. Chairman, the reimbursement systems for skilled nursing facilities under Medicare and its coverage determinations as to who is entitled to skilled nursing benefits have been major reasons why nursing home facilities do not participate in the Medicare Program.

In your own State, 75 to 80 percent of the nursing home facilities do not participate in Medicare.

In 50 percent of the rural counties in this country, there are no SNF's participating in Medicare. In your State, there are only two rural facilities which participate as a Medicare SNF. Why? Two basic reasons. Reimbursement is the first. Given the nature of the reimbursement system for skilled nursing facilities under Medicare, which is the same system in place prior to the PPS for hospitals, it forces skilled nursing facilities to take a loss unless they have sufficient volume of Medicare patients to create a distinct qualification under the program. More specifically, they take a loss for every patient coming into the home.

There are other problems related to reimbursement. There is the fact that next year payment to the skilled nursing facility after the 20th day will rise to $61.50, which, for a significant number of facilities in the country is the cost of caring for the patient over the course of a day.

We think in the reimbursement area there are solutions. This year's Senate Finance Committee reconciliation package includes a proposal which would at least help in terms of low-volume Medicare providers. The proposal would require establishment of a prospective rate which in effect would be tied to the average cost of care of a Medicare patient in a skilled nursing facility rather than of a Medicaid patient whose cure is less costly, but who makes up a major part of a facility's population. the Finance Committee's proposal would also require that the Medicare prospective payment depend on the average rate in the particular geographic area. We support that approach.

The other basic problem which contributes to low participation by SNF's in Medicare is the coverage issue. Even though a beneficiary is eligible for Medicare, it by no means assures his or her eligibility for nursing home coverage.

As Senator Pepper suggested, as far as long-term care is concerned, the Medicare Program is essentially a sham. By statute, the SNF benefit provides only 100 days of care which must follow a 3-day hospital stay. Only rehabilitative services or skilled nursing services are covered. Unfortunately, coverage determinations by intermediaries are incredibly inconsistent.

Furthermore, earlier this year the Health Care Financing Administration, proposed removal of the presumptive status, the waiver of liability provision which allowed nursing homes and other providers a cushion for coverage denials made in eligibility determinations. Fortunately in its reconciliation package, the Senate Finance Committee proposed a moratorium on this action.

With respect to coverage, we think there are some potential changes that might take place. The 3-day stay requirement, which qualifies patients for skilled nursing facility services, may have been appropriate when the Medicare Program was first in place. However, advanced medical technology has drastically altered the need for this requirement.

For example, cataract surgery which might indeed have occasioned 4 or 5 days in the hospital 20 years ago is now in many cases not even a hospital service. Even hip fractures in many cases requires only 2 or 3 days of acute hospital stay before they are able to be transferred to a nursing home.

Regarding the 3-day hospital stay requirement. We would suggest that the Health Care Financing Administration use the authority granted them by the Congress in the Tax Equity and Fiscal Responsibility Act of 1982 which states that the HHS Secretary may waive the 3-day requirement if such a wavier would not lead to an increase in costs.

Finally, with respect to general Medicare coverage decisions, we would suggest we get the beneficiary and the provider out of the middle and simply have prior determinations made. We, as providers, know what the hospital discharge diagnosis is, we know the therapies required. Let's work it out upfront, and get away from presumptive status and waiver of liability. It is time to eliminate a situation which places the beneficiary or the provider in the middle. HCFA needs to review the issue thoroughly before eliminating this provision.

Thank you very much.

[Testimony resumes on p. 326.]

[The prepared statement of Mr. Willging follows:]

PREPARED STATEMENT OF PAUL R. WILLGING, PH.D.

Mr. Chairman and Members of the Task Force on Health.

I am Paul Willging, Executive Vice President of the American Health Care Association. AHCA is the largest association representing about 9000 of America's for-profit and not-for-profit long term care providers.

Several years ago, the Congress acted responsibly in reforming the Medicare payment method for hospitals. Legislation was enacted which moved hospitals off retrospective, cost reimbursement in 1982 to a target rate program and then in 1983 to a 3 year phase-in of the diagnostic-related group (DRG) prospective payment system.

As the hospital DRG payment system was put into place throughout the nation, evidence showed that it was acheiving the objectives Congress had set out--namely to decrease Medicare patients' lengths of stays in hospitals and to discharge or transfer them earlier to long term care facilities or their homes where they would complete their convalescence. Unfortunately, however, while Congress focused its attention on the Medicare acute care area, it sorely neglected the skilled nursing facility (SNF) component which was now being pressured to provide follow-up services to these hospitals' newly discharged, often more acutely ill patients.

No forethought was given to whether there would be beds or services available to these patients once they left the hospital or more importantly, who was going to pay for health services they still required.

The evidence is overwhelming that the Medicare SNF system is broken, but it can be fixed. The problems of patient access to needed SNF services, already acute in many areas of the country, are worsening because of DRG impacts and an outmoded payment methodology.

MEDICARE REIMBURSEMENT

I would like to highlight the major failings of the present reimbursement system and then suggest what can be done now so as to lay the groundwork for achieving the benefits of an ideal system.

OBSTACLES TO PATIENT ACCESS TO SERVICES

- Low provider participation in Medicare. Less than 1/3 of the nursing homes have even sought Medicare certification. A major reason for provider reluctance is the complexity of Medicare reimbursement. Many providers initially in the program have terminated participation.
- Geographic disparities in Medicare SNF availability:
  - Only 25% of the SNFs are in rural areas.
  - 30% of SNF patient days are concentrated in 2 states, 50% in 6 states.
  - 9% of the SNFs provide fully 40% of patient days and 40% of the SNFs provide only 9% of the patient days.

- -- Beds average 18/1000 elderly beneficiaries, ranging from 1 (Arkansas and Oklahoma) to 51 (North Dakota).
- -- Patient days average 310/1000 elderly beneficiaries, ranging from 1 day (Wyoming) to 635 days (Kentucky).

o Increasing demand for SNF beds. This is a direct impact of DRG incentives for hospitals to discharge patients in greater numbers to SNFs.

o Financial disincentives for admission of "heavy care" patients. This long-standing problem is worsening with the DRG incentive for earlier hospital discharges.

AHCA Recommendation

Despite claims by the Health Care Financing Administration that there was not sufficient data and experience to develop a prospective payment plan for SNFs this year, our reply was that there are sufficient data and experience to know that the present method fails everyone.

What we offered to Congress was a constructive and cost-effective way to deal with the SNF payment method problems, a transitional program which would serve as an expeditious way to develop the precision and refinements of an ideal system.

In brief, AHCA's recommendation transitional system features the following:

o Prospective rates covering all operating and most direct patient care expenses. Rates would be based on a facility's reported costs, indexed forward, up to a ceiling fixed by the costs of comparable facilities. The ceiling concept is similar to the existing "Section 223" limits on routine costs.

o Per unit payment for a small number of special ancillary services (e.g., therapies) with high cost and highly variable utilization. Currently, certain services are separately paid.

o Efficiency incentive payments for keeping costs below the ceiling. A facility would receive a proportion of the difference between the ceiling and its prospective rate, limited to a percentage of the ceiling.

o The prospective rate and ceiling computations would include actual capital costs paid plus a simple percentage add-on for growth and return on investment.

o For the many facilities with low Medicare volume, rates would be set at the ceiling, rather than reported costs.

o Simplified cost reports for those above a Medicare volume threshold and the burden of cost reports eliminated for low volume facilities.

We were pleased that last month as part of its reconciliation package, the Senate Finance Committee approved a more modest step. The Committee agreed that SNFs that provide less than 1500 days of care per year to Medicare patients will have the option of being paid a prospective rate set at 105 percent of the regional mean for all SNFs in the region. The rate would be differentiated for urban and rural areas and include all non-ancillary operating costs, capital costs and return on investment. Only a minimal cost report would be required of those accepting the prospective rate.

We are hopeful that the SNF prospective payment system will be approved by the full Senate and accepted by the House conferees, and that it will serve as a first step towards better patient access to skilled nursing services.

MEDICARE COVERAGE

Indeed the need for action on a SNF prospective payment system is immediate; however, equally necessary are legislative changes to improve the situation for beneficiaries, taxpayers and providers. As the DRGs are phased-in, hospitals have even greater incentives for more patient transfers to SNFs. In addition, these transfers are occurring earlier and involve sicker patients.

Major failings of the systems pretaining to coverage and recommendations for change are outlined below.

Obstacles to Adequate Medicare Coverage

o Skilled nursing care definition. Medicare only covers up to 100 days in a SNF and beneficiaries must require "on a daily basis skilled nursing care provided directly by or requiring the supervision of skilled nursing personnel or other skilled rehabilitation services, which as a practical matter can only be provided in a SNF on an inpatient basis ....." However, the Medicare program has not adapted its coverage to take advantage of the services which can be provided in today's long term health care facilities. Medicare provides no coverage of the most utilized nursing home service--intermediate care nor would patients who need skilled nursing or rehabilitative services regularly, but not necessarily daily, meet eligibility requirements. Although a patient might be better served at a lower overall cost in a SNF, such care would not be covered by Medicare.

AHCA Recommendation

Congress should consider cost-effective opportunities to restructure Medicare nursing home coverage. Based on the experience of Medicaid and prepaid health plans, a less restrictive definition of covered nursing home services should be developed. Medicare should provide coverage for care between SNF services and home health care.

o SNF patient cost sharing. Present cost sharing for SNF patients is excessive, especially relative to other Medicare services. In 1985, a SNF patient, after already having paid the hospital deductible and possibly coinsurance for the required prior hospitalization, paid $50.00 per day from the 21st day to the maximum 100th day of care. In many areas of the country, a $50.00 fee approaches 100 percent of the facility's reimbursement. In contrast, home health recipients pay nothing and hospital patients pay a deductible of $400 for the first 60 days. According to current practices, a Medicare patient in a SNF for the same number of days would be faced with 5 times that amount in copayments: $2000.

AHCA Recommendation

AHCA supports a reduction in the SNF patient's cost sharing and when a SNF prospective payment is implemented, SNF coinsurance should be set at a percentage of the SNF payment rate and not be artificially linked to hospital costs.

- Prior hospitalization requirement. To qualify for SNF services, Medicare beneficiaries must spend at least three days in a hospital. Although a provision in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) gave the HHS Secretary authority to waive the three-day prior hospitalization requirement if such a waiver would not lead to an increase in costs, HHS has taken no action on this issue to date.

  Although HHS contends that elimination of the three-day stay requirement would increase Medicare costs, it should be waived when specific patient conditions can be identified for which the prior hospital requirement is neither cost-effective nor necessary to control inappropriate utilization. Examples of such situations include patients receiving Medicare home health services who develop an intensified nursing need and beneficiaries whose "spell of illness" has not ended because 60 days have not lapsed since their earlier hospital or SNF care.

AHCA Recommendation

Congress should urge HHS to implement expeditiously the cost saving provision included in the 1982 TEFRA and seek a timetable for HHS action. With the strong incentive for hospital admission and earlier transfer of hospital patients as a result of the new Medicare hospital prospective payment system, reform of the prior hospitalization requirement takes on added importance.

- Medicare waiver of liability. The current waiver law is critical to Medicare SNFs because it provides some protection against the kinds of retroactive denials of coverage that motivated over one half of the nation's nursing homes participating in Medicare to leave the program. The waiver of liability guidelines were passed by Congress in 1972 in direct response to providers leaving the program.

  Under the statutory provision, the waiver provides relief to a beneficiary or provider who acted in "good faith" in accepting and providing services, later found by the intermediary to be not reasonable or necessary. Making this determination is often impossible because the "grey areas" are larger than the "black and white." For providers to be held liable for their "good faith" effort is simply ludicrous. Having the waiver has enabled many providers to remain in a program that has few, if any, incentives to be in it in the first place.

  Earlier this year, the Administration took steps to wipe out any remaining vestiges of the Medicare SNF program. On March 14, 1985, it proposed eliminating the waiver of liability, a provision which has afforded nursing homes and other providers a cushion for coverage denials made in eligibility determinations. Only after a coalition of health care consumers, providers and state Medicaid agencies appealed, with the support of Congress, to HCFA to study the matter more thoroughly before taking this action, did the agency postpone its action.

AHCA Recommendation

Last month, the Senate Finance Committee included several provisions in its reconciliation package which would retain the Medicare waiver of liability for nursing homes and home health agencies. There are no similar provisions in the House Ways and Means Committee reconciliation package. AHCA, along with other coalition members has requested Congressional support for retention of those proposals.

Summary

Implementation of the Medicare hospital DRG payment system has had considerable impact on patient access to needed skilled nursing facility services. Hospital-DRG incentives for more patient transfers to SNFs and earlier transfers involving sicker patients has exacerbated the problem. But unless Congress enacts legislation which will change the way nursing home providers are reimbursed under Medicare, problems of access and ultimately quality of care for beneficiaries will worsen. Hospital back-up, in which Medicare patients who no longer require hospital care remain hospitalized awaiting nursing home placement, will increase.

Future policymaking designed to increase patient access to more cost-effective nursing home services is essential. Enacting a prospective payment system for SNFs is the first step.

Furthermore, Congressional consideration of legislative initiatives to broaden the Medicare skilled nursing care definition, reduce SNF patient-cost sharing, and eliminate the prior hospitalization requirement would allow more beneficiaries to receive health services in less costly nursing home beds at less cost to them.

Can Congress afford to refrain from action any longer?

Mr. Frost. Thank you. If you would proceed, Ms. Cushman.

STATEMENT OF MARGARET J. CUSHMAN, M.S.N., R.N., EXECUTIVE VICE PRESIDENT, VISITING NURSE AND HOME CARE, HARTFORD-WATERBURY REGION, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. Cushman. Thank you, Mr. Chairman.

I am Margaret Cushman, executive vice president of Visiting Nurse and Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the secretary of the board of directors for the National Association for Home Care, and as the chairman of NAHC's Government Affairs Committee. NAHC is the Nation's largest association representing home care professionals and paraprofessionals with approximately 3,000 member organizations.

On behalf of these organizations, I would like to commend you for holding these important hearings.

The implementation of the hospital prospective payment system has had a dramatic impact on the home care industry, both in terms of the acuity level and the number of patients needing home care after a hospital discharge.

You have heard of numerous studies and I would like to cite a couple that have not been mentioned. One study in Spokane, WA, on the effects of DRG's found the following impacts on home care: Home care agencies are purchasing or planning purchases of sophisticated IV pumps and hospital beds; securing training for personnel on topics ranging from sophisticated medical equipment to devices for performing very complicated nursing procedures in the home.

They are experiencing an increase of the use of traditional nursing supplies such as skin care products, gauzes, irrigation sets, and IV kits. They are experiencing an increase in demand for delivery of rehabilitation services, especially speech therapy and physical therapy, and they are experiencing an increase in the growth of all kinds of personnel, office and direct service staff to provide care.

A study conducted by the Home Health Assembly of New Jersey documents similiar results. The DRG system in New Jersey has increased the number of hospital referrals to home health care. Home health agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

Impediments to the delivery of home care services: Despite the documented increase in demand for home care services created by the DRG system, the Health Care Financing Administration has sought to curtail the Medicare home care benefit, citing this very increase in use of home care services as justification for developing excessively stringent regulations and policies to govern the home health program. The following administrative actions recently undertaken by HCFA illustrate some of the impediments to the delivery of home care services to medicare beneficiaries:

Intermediaries must show at least a $5 return for every $1 of their budget expended on both medical review and audit review activities under their overall Medicare contract in order to get a satisfactory annual contract evaluation by HCFA.

New coverage compliance review criteria were issued in December 1984 establishing review on a nonrandom sample basis and placing increased scrutiny on homebound status and home health aide utilization.

A proposed regulation was issued on February 12, 1985 which, if adopted, would eliminate the current waiver of liability protection for beneficiaries and HHA's and require them to be 100 percent accurate 100 percent of the time in eligibility and coverage policy determinations.

A manual revision was issued in April 1985 which allows fiscal intermediaries to use statistically invalid and unreliable sampling techniques to select a sample of claims for review to determine an agency's waiver status.

A new set of "minimum data element" focus—HCFA forms 485-488—have been implemented which will increase the level of claims undergoing medical review to over 50 percent. Due to a poorly designed set of computer specifications for use in processing these forms, intermediaries will be performing the increased level of medical reviews on a mainly manual basis, thus slowing down claims processing and cash flow.

A new standard billing form—HCFA form 1450, also known as UB-82—must be implemented by all HHA's by no later than October 1, 1985. In many instances, system design and implementation problems have caused or will cause significant claims processing backlogs, affecting HHA cash flow and ability to render services.

In the midst of implementing the new data element forms and billing forms, HCFA will be instituting a new regional intermediary system sometime between October 1, 1985 and January 1, 1986, shifting 85 percent of all HHA's from their current intermediaries—there are 47 statewide intermediaries now—to a regional system of 10 intermediaries.

An accounting policy on discrete costing is in effect which discourages HHA's from diversifying into non-Medicare program areas at the risk of having the non-Medicare program absorb a disproportionate share of overhead created by the Medicare Program.

On July 5, 1985, HCFA established a new schedule of cost per visit limits for HHA's based on highly questionable data and methodology and inappropriate notice which will have the effect of closing many HHA's; severely limiting agencies' ability to deliver many services, particularly in rural areas; and limit many agencies' ability to delivery indigent care and "hi-tech" care.

I could go on and on about all the different restrictions that have taken place.

While the hospital prospective payment system encourages the use of noninstitutional services, the ability of home health agencies to deliver the medically necessary services patients require upon discharge has been seriously eroded by the recent actions of the Health Care Financing Administration. At a time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans.

Mr. Chairman, I appreciate having this opportunity to testify on the impact of DRG's on home health care and I would be happy to answer any questions you may have.

Thank you, Mr. Chairman.

[Testimony resumes on p. 334.]

[The prepared statement of Ms. Cushman follows:]

Prepared Statement of Margaret J. Cushman

Mr. Chairman and Members of the Committee:

My name is Margaret Cushman. In am the Executive Vice President of Visiting Nurse And Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the Secretary of the Board of Directors for the Natiional Association for Home Care (NAHC), and as the Chairman of NAHC's Government Affairs Committee. NAHC is the nation's largest Association representing home care professionals and paraprofessionals with approximately 3000 member organizations. On behalf of these organizations, I would like to commend you for holding these important hearings.

I. Impact of DRGs on the Home Health Industry

The implementation of the hospital prospective payment system has had a dramatic impact on the home care industry, both in terms of the acuity level and the number of patients needing home care after a hospital discharge. In addition to the volume of anecdotal evidence from home care providers relating that patients are being released from hospitals "quicker and sicker" since the implementation of DRGs, there have now been several studies documenting this occurence. Last fall, in response to a request by Senator John Heinz, Chairman of the Senate Special Committee on Aging, the General Accounting Office (GAO) prepared a report which concluded that under the DRG system, patients were in fact being released from hospitals more quickly and in a sicker condition. The Eastern Washington Area Agency on Aging (EWAAA) in Spokane, Washington recently conducted a study on the effect of DRGs on community based agencies in Eastern Washington State. This study concluded that home health agencies are bearing the brunt of the effects of earlier discharges under the DRG system. The study found that under the DRG system, the number of reimbursable home visits rose 27% for urban home health providers, based on six month data for comparable periods during 1983 and 1984, and that professional nursing visits rose 37% in urban areas and 18% in rural areas. In response to the increased acuity of patients being seen in the home, the study found that home care providers are:

- Purchasing or planning purchases of more sophisticated equipment such as intravenous pumps and hospital beds.
- Securing training for personnel on topics ranging from the use of more sophisticated medical equipment and devices to the performance in the home of complicated nursing procedures.
- Experiencing an increase in the use of traditional nursing supplies such as skin care products, gauzes, irrigation sets, and intravenous kits.
- Experiencing an increase in the demand for the delivery of rehabilitative services, expecially speech and physical therapy services.

- Experiencing an increase in the growth of staff nurses, aides, and office personnel. At one agency, the number of full time RNs rose from 11 to 45 between June 1983 and June 1984, home health aides increased from 17 to 25 FTEs, and physical therapy staff increased from one to two members.

A study conducted by the Home Health Assembly of New Jersey documents similar results. In 1980, New Jersey became the first state to implement a prospective payment system for hospitals based on DRGs. The New Jersey study found that:

1. The DRG system in New Jersey has increased the number of hospital referrals to home health care.

   New Jersey's hospitals were phased into the DRG system over a three year period: 1980, 1981 and 1982. According to the New Jersey Health Department the average length of stay in 1979 (pre-DRG) for the seven most common types of licensed hospital beds was 7.43 days; this figure dropped to 7.0 days in 1982 and decreased farther, to 6.39 days in 1983. (By comparison, the Department of Health and Human Services reports a reduction in average length of stay in the Medicare program from 9.5 days to 7.5 days after the first full year of the federal prospective payment system.)

   In a data report, compiled in cooperation with the New Jersey Department of Health, the Home Health Agency Assembly of New Jersey found that the number of admissions to home health agencies from hospitals jumped from 61% to 68% of total admissions between 1980 and 1981, the first year of phase-in for the DRG system in New Jersey. Since 1981, hospital referrals have remained a constant 67% of total admissions for home health care. The net impact of the DRG system is an increase of 8,000 admissions to home health care in 1983. There were a total of 133,000 persons served by home health agencies in New Jersey in 1983.

2. Home health agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges.

   Over the same four year period during which the average length of stay steadily dropped, the number of high technology services offered by home health agencies grew dramatically. According to 1983 data, the following services were offered by a significant number of home health agencies:

TYPES OF PROGRAMS AVAILABLE (1983)

	NUMBER	PERCENT
Home Catheter Care	50	98.0
Tracheostomy Care	45	88.0
Intravenous Therapy	26	51.0
Respiratory Therapy (MIA Respirator)	17	33.0
Chemotherapy	13	25.5

The growth in high technology services experienced over the period paralleling the DRG implementation years suggests a relationship between the two events, explained by the introduction of more acutely ill patients into the home health care setting.

3. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

The trend to expanded hours of operation, both business hours and service hours, is the most striking change in home health agency operations since the implementation of the DRG system. Eighty-two percent of home health agencies in New Jersey schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

II. Impediments to the Delivery of Home Care Services

Despite the documented increase in demand for home care services created by the DRG system, the Health Care Financing Administration has sought to curtail the Medicare home care benefit, citing this very increase in use of home care services as justification for developing excessively stringent regulations and policies to govern the home health program. The following administrative actions recently undertaken by HCFA illustrate some of the impediments to the delivery of home care services to Medicare beneficiaries:

* Intermediaries must show at least a $5 return for every $1 of their budget expended on both medical review and audit review activities under their overall Medicare contract in order to get a satisfactory rating on their annual contract evaluation by HCFA.

* New coverage compliance review (CCR) criteria were issued in December 1984, establishing review on a non-random sample basis and placing increased scrutiny on "homebound" status and home health aide utilization.

* A proposed regulation was issued on February 12, 1985 which, if adopted, would eliminate the current "waiver of liability" protection for beneficiaries and HHAs and require them to be 100 percent accurate 100 percent of the time in eligibility and coverage policy determiniations.

* A manual revision was issued in April 1985 which allows fiscal intermediaries to use statistically invalid and unreliable sampling techniques to select a sample of claims for review to determine an agency's waiver status.

- A new set of "minimum data element" focus (HCFA Forms 485-488) have been implemented which will increase the level of claims undergoing medical review to over 50 percent. Due to a poorly-designed set of computer specifications for use in processing these forms, intermediaries will be performing the increased level of medical reviews on a mainly manual basis, thus slowing down claims processing and cash flow.

- A new standard billing form (HCFA Form 1450, also known as UB-82) must be implemented by all HHAs by no later than October 1, 1985. In many instances, system design and implementation problems have caused or will cause significant claims processing backlogs, affecting HHA cash flow and ability to render services.

- In the midst of implementing the new data element forms and billing forms, HCFA will be instituting a new regional intermediary system sometime between October 1, 1985 and January 1, 1986 shifting 85 percent of all HHAs from their current intermediaries (there are 47 statewide intermediaries now) to a regional system of ten intermediaries.

- An accounting policy on "discrete costing" is in effect which discourages HHAs from diversifying into non-Medicare program areas at the risk of having the non-Medicare programs absorb a disproportionate share of overhead created by the Medicare program.

- On July 5, 1985 HCFA established a new schedule of cost per visit limits for HHAs based on highly questionable data and methodology and inappropriate notice which will have the effect of closing many HHAs; severely limiting agencies ability to deliver many services, particularly in rural areas; and limit many agencies ability to deliver indigent care and "hi tech" care.

- HCFA proposed, in President Reagan's FY 1986 budget, to impose a copayment equal tc one percent of the inpatient hospital deductible for every home health visit starting with the 21st visit in a calendar year. If implemented for FY'86, this would mean beneficiaries would pay a $4.80 copayment starting with the 21st visit.

- A January 1984 manual change prohibits beneficiaries from designating HHA employees as their representatives in claims denial appeals. This policy is being challenged by NAHC in a lawsuit.

- A policy has been instituted creating the legal fiction of a "technical denial" which prohibits HHAs from appealing any claims denied on a "technical denial" basis.

- A policy has been instituted whereby HCFA, through its intermediaries, use a questionable sampling methodology to sample claims and project the denial rate to an agency's entire caseload resulting in a demand for repayment prior to any appeals. NAHC has initiated a challenge to this illegal policy which already has resulted in a favorable Administrative Law Judge ruling in New Mexico.

- HCFA will not pay for home intravenous antibiotic therapy supplies, equipment or services.

- HCFA will pay for home intravenous chemotherapy supplies, equipment and services only on a limited basis.

- The regulations governing the Medicaid 2176 Home and Community-Based waiver programs, designed to encourage states to broaden Medicaid home coverage for targeted needy populations, were revised March 13, 1985 creating onerous new paperwork requirements and qualifying standards so as to discourage states from participating.

Summary and Conclusions

While the hospital prospective payment system encourages the use of non-institutional services, the ability of home health agencies deliver the medically necessary services patients require upon discharge has been seriously eroded by the recent actions of the Health Care Financing Administration. At a time of increasing concern about the expenditure of Federal money on health services, home healtn care is a humane and cost-effective alternative to institutionlization for elderly and disabled Americans.

Mr. Chairman, I appreciate having this opportunity to testify on the impact of DRGs on home health care and I would be happy to answer any questions you may have.

Mr. FROST. Thank you, Ms. Cushman. Next we have Mary Fisher for the American Nurses' Association.

STATEMENT OF MARY FISHER, M.S.N., R.N. DIRECTOR OF NURSING, THOMAS JEFFERSON HEALTH DISTRICT, VIRGINIA, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION [ANA]

Ms. FISHER. Mr. Chairman, I am Mary Fisher, director of nursing for the Thomas Jefferson Health District, which consists of five rural counties and Charlottesville, VA. I appreciate this opportunity to present the views of the 185,000 members of the American Nurses' Association regarding the impact of the hospital prospective payment system on the quality of care provided to medicare beneficiaries.

Mr. Chairman, in your opening remarks at the first in this series of hearings, you succinctly described the delicate balancing act that Federal decisionmakers must undertake with respect to Medicare. You noted that decisions about Medicare funding must be "consistent with the deficit reduction effort, while ensuring that Medicare remains financially sound and able to meet the health care needs of millions of Americans."

ANA shares your concern that, although the new prospective payment system is still in the process of being implemented, Medicare continues to be a prime target of deficit reduction efforts.

I would like to say something off the record.

[Discussion off the record.]

Ms. FISHER. The two questions we asked in our study were, Are there changes in patterns of referrals from hospital to home health care? Two, if so, what are the direction and magnitude of these changes? The study describes observed changes in home health nursing service referral patterns and associated nursing service changes.

Stage 1 looked at all referrals for home health from a small community hospital in Virginia for 6 months before and after DRG's. Stage 2 looked at referrals for home health from a medium-sized acute care/general medical and surgical hospital in Virginia for 6 months before and after DRG's.

The most sigificant finding from stage 1 of the study was that: Home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRG's. Requests for daily visits rose from 11 percent pre-DRG to 22 percent post-DRG; requests for visits three times per week rose from zero percent pre-DRG to 11 percent post-DRG. The intensity of nursing services also increased from a pre-DRG mean of 2.22 to a post-DRG mean of 2.83.

The abstract of the completed research from stage 2 of the study will be presented soon. Analysis of nursing resource consumption in stage 2 confirmed stage 1 findings that home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRG's in the primary referral hospital.

While studies and surveys provide helpful information, I believe the following anecdotal evidence will vividly highlight the types of problem situations involving medicare patients that our nurses are encountering.

The three patient situations I will describe involve Medicare patients who are either elderly or disabled. The first one is an example of a late referral being made by a hospital to the community health agency. In this situation, it was a 62-year-old disabled man with acquired immune deficiency syndrome and diminished mental capacities who was discharged from the hospital on a Saturday. There was no agency referral from the hospital until the following Monday. While the hospital nurses had provided some instructions to the patient and family on prevention of the spread of AIDS virus through proper handling of his body fluids, the devastating nature of this disease required time for extensive education and adaptation by the patient and family to the home environment.

Without adequate education about the ways to prevent the spread of the AIDS virus to family members, there was an increased risk of disease transmission to the rest of the family. AIDS has been declared America's No. 1 public health priority by the Public Health Service and thus necessitates that proper patient and family education be provided. Late referrals decrease the time available for sufficient instruction of the patient and family and preparation of the home environment.

The second case was a 68-year-old woman with amyotrophic lateral sclerosis—Lou Gehrig's disease—and nine additional diagnoses who was discharged home directly from the medical intensive care unit with 13 pages of care instructions for her family. She had a tracheostomy and was on a ventilator, required tube feedings, was on nine medications—including an anticoagulant medication that involved daily injections—and needed special skin care. No nursing home would take her because she was respirator-dependent. She was, therefore, totally dependent on her husband and one of her children for care beyond the daily and sometimes twice a day visits by the community health nurse. This dependency had a very negative impact on the family, to the degree that officials from the protective services agency had to be called in to deal with spousal abuse. While cases of spousal abuse are rare, many families experience frustration and guilt at their inability to provide the highly technical care that the patient requires.

Prior to PPS, this woman probably would not have gone home before her death from ALS. The increased level of care, sometimes critical care, that patients now require posthospitalization is placing great demands on community health nurses. In some instances, unfortunately, lesser prepared health personnel are being hired to perform highly technical procedures that they are not qualified to perform. Community health patients have a right to receive safe, competent health care.

The third case is a 23-year-old woman who was mentally retarded, diabetic, obese, hypertensive, and developed a very large leg ulcer. A for-profit home health agency was willing to care for the woman when her condition only required a dressing change. It became apparent that there was a possibility that she might lose her leg, and that she needed health teaching for diet, hypertension, and diabetic control. Because this complex care was not a covered benefit, the for-profit agency refused to continue to provide services. Fortunately, our agency was able to provide the intense case management that was required because of the involvement of the physicians, the hospital, and other services. This woman is no longer in danger of losing her leg. She is now living in the State training school for the mentally retarded where she is receiving the help she needs to control her complex medical problems. The family is relieved that this woman is not an amputee for the rest of her life.

Mr. Chairman, in light of such examples, we offer several recommendations for improvements in the current status of Medicare.

First, peer review organizations should be mandated to do more quality assurance monitoring and enforcing activities, especially as relates to inappropriate and premature discharges.

Two, services such as counseling and preventive health services should be covered as home health benefits. Frequently when you are dealing with a terminally ill patient, you have a situation in which the whole family is severely impacted and counseling frequently is not covered in those situations.

Third, the current level of community-based services available to Medicare beneficiaries is inadequate to handle their health needs. Alternative health care delivery systems such as freestanding nursing centers should be considered.

In summary, when policy and funding decisions for Medicare are debated, cost containment must be balanced with quality of care and access issues. If we control costs at the expense of the elderly, our health care policy is nothing less than a failure.

Mr. Chairman, ANA appreciates your consideration of our views. If there are any questions, I would be happy to address them.

[Testimony resumes on p. 344.]

[The statement of Ms. Fisher follows:]

PREPARED STATEMENT OF MARY FISHER, M.S.N., R.N.

Mr. Chairman, I am Mary Fisher, Director of Nursing for the Thomas Jefferson Health District, which consists of five rural counties and Charlottesville, Virginia. I appreciate this opportunity to present the views of the 185,000 members of the American Nurses' Association (ANA) regarding the impact of the hospital prospective payment system (PPS) on the quality of care provided to Medicare beneficiaries.

Our agency nurses have come to realize that while PPS has resulted in more efficient use of health care resources, it has also resulted in patients being released from the hospital "quicker and sicker." Some patients are even being discharged directly from intensive care units while still requiring such complex medical equipment as respirators, suction machines, nasogastric tubes, urinary catheters and continuous oxygen. The hospital nurses and the community health nurses must spend a more extensive amount of time providing to patients and their families the necessary information and instructions that will enable them to maintain safe, competent care in the home.

Mr. Chairman, in your opening remarks at the first in this series of hearings, you succinctly described the delicate balancing act that federal decision-makers must undertake with respect to Medicare. You noted that decisions about Medicare funding must be "consistent with the deficit reduction effort, while ensuring that Medicare remains financially sound and able to meet the health care needs of millions of Americans."

ANA shares your concern that, although the new prospective payment system is still in the process of being implemented, Medicare continues to be a prime target of deficit reduction efforts. While the fiscal year (FY) 1986 budget resolution reduced Medicare outlays by $2.5 billion for FY86 and by $11 billion over the next three years, it is anticipated that the Administration will seek additional Medicare cuts in its FY87 budget proposal. The Hospital Insurance Trust Fund, which pays for the hospital inpatient part of Medicare, is currently solvent. Dr. Rudolph Penner, Director of the Congressional Budget Office, in his testimony at an earlier hearing noted that even with a 1% increase in the diagnosis related groups (DRGs) payments in FY86, the trust fund will probably be solvent into the 21st century. Any additional cuts in Medicare funding, however, will disrupt the delicate balance between fiscal responsibility, the provision of quality health care, and adequate access to health care that we all strive to achieve. The burden of deficit reduction should not be placed on members of society's most vulnerable groups who have already borne more than their fair share of budget cuts in recent years.

While the specific impact that PPS has had on the health care delivery system is still under evaluation, preliminary research findings and anecdotal evidence already available indicate that, in addition to the effect that PPS has had on hospital services, it has also had a significant impact on non-hospital community health services. A 1985 preliminary report from the U.S. General Accounting Office addressed the impact of PPS on post-hospital care. The report stated that there has been an increase in the use of nursing home and home health care services by Medicare beneficiaries.

The fact that changes in the hospital reimbursement structures have had a ripple effect on community health services can be explained by the "balloon theory." When you squeeze the middle of the health care "balloon" by shortening hospital lengths of stay and discharging hospital patients at reduced functional levels, you enlarge both ends of the health care "balloon" - meaning that there is an increase in the health care services being provided both pre-hospitalization and post-hospitalization. As the providers of the largest proportion of client care in the community health arena, community health nurses are in a unique position to see the extra-hospitalization impact that PPS has had on the quality of care provided to Medicare beneficiaries.

Several nursing colleagues and I recently completed a two-stage study, which was partially funded by a grant from the Department of Health and Human Services. The impetus for this study came from reports by local public health nurses in the spring of 1984 of a shift in patterns of care from more routine care for diabetics and indwelling urinary catheters to more complex care including indwelling arterial-venous catheters and intravenous antibiotics. There appeared to be a need to document these kinds of changes in referrals and patient needs in order to plan manpower and service responses. Two questions were addressed in the study: 1) Are there changes in patterns of referrals from hospital to home health care? 2) If so, what are the direction and magnitude of these changes? The study describes observed changes in home health nursing service referral patterns and associated nursing service changes. Stage 1 looked at all referrals for home health from a small community hospital in Virginia for six months before and after DRGs. Stage 2 looked at referrals for home health from a medium-sized acute care/general medical and surgical hospital in Virginia for six months before and after DRGs.

The most significant finding from Stage 1 of the study was that:

- Home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRGs. Requests for daily visits rose from 11% pre-DRG to 22% post-DRG; requests for visits three times per week rose from 0% pre-DRG to 11% post-DRG. The intensity of nursing services also increased from a pre-DRG mean of 2.22 to a post-DRG mean of 2.83.

The abstract of the completed research from Stage 2 of the study will be presented soon. Analysis of nursing resource consumption in Stage 2 confirmed

Stage I findings that home health care patients required significantly more frequent visitation and more intense nursing services after the implementation of DRGs in the primary referral hospital.

Another recent study drew similar conclusions. The 1985 study by the Southwest Long Term Care Gerontology Center at the University of Texas Health Science Center at Dallas, in cooperation with the National Association of Area Agencies on Aging, reported the findings of a national survey of Area Agencies on Aging concerning changes in service demand and service delivery patterns under DRGs. Area Agencies on Aging are mandated by Congress to plan and coordinate all community-based services for older adults.

Major findings in the report indicate that after the implementation of PPS:

- There was a major shift in service delivery patterns. Case management services increased 365%, in-home skilled nursing increased 196%, housekeeping services increased 69%, and personal care increased 63%.
- The length of time and number of visits per client both increased. This trend is more dramatic among those agencies where DRGs have been in effect the longest. Some agencies have been forced to cut number of service units per client in order to provide services for a longer period of time.
- The greatest demand on agencies by hospitals was for coordination of multiple community services for older persons and their family caregivers, and for personal care services.
- Inadequate family support was a major reason for readmission to hospitals. It is this one service area, however, for which a decrease in service units was documented.

A recent congressional study yielded similar findings. In March 1985, the Task Force on the Rural Elderly of the House Select Committee on Aging released the results of a Prospective Payment Survey sent to State Long-Term Care Ombudsmen. These Ombudsmen oversee problems of patients in nursing homes and are paid by the Administration on Aging.

The results indicated that problems regarding quality health care and access to health care, especially in rural areas, appear to have been exacerbated with the introduction of PPS. Specific findings include:

- An overwhelming majority said patients are discharged sicker than before PPS and, therefore, more were in need of skilled nursing care.
- Existing skilled nursing services are not adequate to meet the needs of discharged patients in all cases.
- It is increasingly difficult for patients to find skilled nursing facility beds or secure necessary home health care.

While studies and surveys provide helpful information, I believe the following anecdotal evidence will vividly highlight the types of problem situations involving Medicare patients that our nurses are encountering:

1. Late referrals are being made by hospitals to the community health agency.

   Case History: A 62 year old disabled man with acquired immune deficiency syndrome (AIDS) and diminished mental capabilities was discharged from the hospital on a Saturday. There was no agency referral from the hospital until Monday. While the hospital nurses had provided some instructions to the patient and family on prevention of the spread of AIDS virus through properly handling of his body fluids, the devastating nature of this disease required time for extensive education and adaptation by the patient and family to the home environment. Without adequate education about the ways to prevent the spread of the AIDS virus to family members, there was an increased risk of disease transmission to the rest of the family. AIDS has been declared America's number one public health priority by the Public Health Service and thus necessitates that proper patient and family education be provided. Late referrals decrease the time available for sufficient instruction of the patient and family and preparation of the home environment.

2. Patients are discharged home, sometimes directly from critical care units, with complicated equipment requiring highly technological care.

   Case History: A 68 year old woman with amyotrophic lateral sclerosis (Lou Gehrig's disease) and nine additional diagnoses was discharged home directly from the medical intensive care unit, with 13 pages of care instructions for her family. She had a tracheostomy and was on a ventilator, required tube feedings, was on nine medications (including an anticoagulant medication that involved daily injections) and needed special skin care. No nursing home would take her because she was respirator-dependent. She was, therefore, totally dependent on her husband and one of her children for care beyond the daily and sometimes twice a day visits by the community health nurse. This dependency had a very negative impact on the family, to the degree that officials from the protective services agency had to be called in to deal with spousal abuse. While cases of spousal abuse are rare, many families experience frustration and guilt at their inability to provide the highly technical care that the patient requires.

Prior to PPS, this woman probably would not have gone home before her death from ALS. The increased level of care, sometimes critical care, that patients now require post-hospitalization is placing great demands on community health nurses. In some instances, unfortunately, lesser-prepared health personnel are being hired to perform highly technical procedures that they are not qualified to perform. Community health patients have a right to receive safe, competent health care.

3. The "dumping" of non-profitable patients by for-profit home health agencies.

Case History: A 23 year old woman who was mentally retarded, diabetic, obese and hypertensive developed a very large leg ulcer. A for-profit home health agency was willing to care for the woman when her condition only required a dressing change. When it became apparent that there was a possibility that she might lose her leg, and the need for control of diet, hypertension, and diabetic behavior modification warranted more complex care. Because this complex care was not a covered benefit, the for-profit agency refused to continue to provide services. Fortunately, our agency was able to provide the intense case management that was required because of the involvement of the physicians, the hospital and other services. This woman is no longer in danger of losing her leg. She is now living in the State Training School for the Mentally Retarded where she is receiving the help she needs to control her complex medical problems.

The impact of PPS on the quality of care provided to Medicare beneficiaries was the topic of a recent Senate hearing. The September 26, 1985 Staff Report of the Senate Special Committee on Aging on the "Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries" made the following findings: seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals; hospital patients who live alone and are too sick to appeal hospital discharge decisions are without any protection under PPS; many patients, especially the terminally ill and their families, are being given false and incomplete information on their rights of discharge appeal and on options for post-hospital care; and some hospitals have denied admission to patients with multiple serious conditions.

The American Nurses' Association has several recommendations for improvements in the current status of Medicare, the first two of which are similar to recommendations contained in the Staff Report of the Senate Special Committee on Aging.

1. Peer Review Organizations (PROs) should be mandated to do more quality assurance monitoring and enforcement activities, especially as it relates to inappropriate and premature discharges.
2. The DRG classification system should be changed to better reflect differences in severity of illness between patients in the same DRG category so that hospitals receive sufficient payment to provide adequate care.
3. Services such as counseling, health education and other health prevention services should be included as covered home health benefits.
4. The onset of PPS has placed such great demands on the community-based care systems, that the current level of community-based services available to Medicare beneficiaries is inadequate to handle their health needs. This fact should compel Congress to increase the community resources available to satisfy the increased need. Development and use of alternative health care delivery systems, such as freestanding nurse-managed centers, is one viable option.
5. Congress should request that a study be done on the impact that PPS has specifically had on community-based care systems.

In summary, when policy and funding decisions for Medicare are debated, cost containment must be balanced with quality of care and access issues. For if we control costs at the expense of the elderly, our health care policy is nothing less than a failure.

Mr. Chairman, ANA appreciates you consideration of our views and looks forward to working with you on this issue.

Mr. **Frost**. Thank you, Ms. Fisher.

Well, I would address this to any of the three of you. Do you consider that the current payment under Medicare for home health services is adequate? And what changes would you make if you do not think so, for home health visits?

Ms. **Cushman**. In general, the current level of payment for that which is considered reimbursable is generally adequate under the current system.

Mr. **Frost**. Is generally?

Ms. **Cushman**. Generally adequate under the current system.

The proposed cost cap limits, however, and the change in the method of costing being applied, would severely impact home care agencies. I think the health care financing agency estimated 70 percent of the agencies would be in trouble within the 3-year period that caps would apply.

Mr. **Frost**. Are you talking about a limit on the number of visits or a limit of reimbursements?

Ms. **Cushman**. The cost limit issue would limit the reimbursement per visit.

There is also inadequate coverage under current policy for the number of visits allowed according to the frequency. That is the intermittent care issue I addressed. Where a maximum of 2 to 3 weeks totally will be covered for daily care. Beyond that it must be justified as exceptional circumstances for a maximum of another 2 to 3 weeks. Beyond that, daily care would not be covered.

Some of the patients we are seeing discharged require daily, twice daily, and sometimes three times daily care for a long period.

Mr. **Frost**. I note that in your testimony. And when you say two or three, twice or three times daily, how much time is spent on each one of those visits?

Ms. **Cushman**. The average length of a visit has traditionally been in the area of 45 minutes to an hour in the home. We also find that with the higher technological procedures, that is increasing.

I know most particularly one agency in the State of Texas, the Dallas agency, is experiencing something like three times that length of visits for new admissions for high technology procedures.

Mr. **Frost**. There was, of course, last year a proposal by the administration to limit the number of visits that would be reimbursable.

Ms. **Cushman**. That is correct.

Mr. **Frost**. I assume that you would be opposed to that.

Ms. **Cushman**. Most definitely.

Mr. **Frost**. What happens to the severely——

Ms. **Fisher**. I could only speak for the district I represent. Frequently, nurses must drive an hour to get to the patient, spend about an hour with the patient, and then spend another hour driving back. So our costs do not fall within our allotted program funding frequently because we serve a very large rural area with the inherent difficulty of access to many of our patients. This geographic factor increases our time and costs.

Mr. **Frost**. What about the patient who requires more than an hour, that really requires someone to be there virtually the entire time? What happens to that patient who is discharged from a hospital, who may choose to go home, who may choose to spend the remaining months of his or her life at home? Can your agencies help those patients adequately, or who takes care of those patients?

Ms. CUSHMAN. Again, I think our agencies can take care of the patients. The Medicare Program does not acknowledge that type of coverage. I referred to the selective billing concern earlier. This is most troublesome when a patient is prepared to purchase the additional coverages, but Medicare says their care is no longer intermittent, Medicare refuses to pay even for intermittent service.

Mr. FROST. Who should be paying for the patient who needs round-the-clock care at home?

Ms. CUSHMAN. I think that depends upon the nature of the patient and how long the client will require that type of care. In some instances, it makes sense for the Medicare Program to cover round-the-clock care, and certainly the Hospice Program has a continuous care payment built into the benefit.

Mr. WILLGING. Perhaps a more critical question is, what are the responsibilities of the Medicare Program with respect to long-term care, be it institutional long-term care, which is essentially what I represent, or home care? I think it is somewhat scandalous that one, the average length of stay of a patient admitted under Medicare to a skilled nursing facility is 60 days; two, the average payment by Medicare for the patient is 29 days; and three, the patient is paying out of pocket those additional 30 days just because he or she is unfortunate enough to be the recipient of some of these arcane Medicare coverage decisions which are partially in statute, partially in regulation and partially due, to some extent, to the whims of Health Care Finance Administration officials.

Mr. FROST. I really—this may be a question you simply can't answer, but what happens to the terminally ill patient who may have a month to live and who chooses to spend that time at home, with his or her family, and needs the round-the-clock care? Should that be an obligation of Medicare?

Mr. WILLGING. I would certainly think it should be.

Ms. CUSHMAN. The Medicare hospice benefit was designed to address that problem. Due to a lot of circumstances surrounding that benefit, a large number of hospices have elected not to go for Medicare certification, so that isn't available to our clients.

Other individuals can purchase the care. Many choose not to. And in some areas they simply are unable to afford it.

Ms. FISHER. It is a lot less expensive in many situations to not have that person institutionalized.

Again, I would have to speak for the more rural areas. Our hospice is staffed with volunteers. You can't ask volunteers to provide that type of care. Frequently, we help piece together needed care givers from a variety of sources, the area agency, hospice, churches, friends, et cetera, which certainly gives the family a sense of support.

And I guess I do keep coming back to the need to work with the entire family in many situations. The way Medicare is written now, it does not cover the terminally ill patient if they physically are stable. While many terminally ill patients do go through a stable time physically and emotionally. They and their families would continue to benefit from counseling and other types of support that are currently not covered in these types of cases.

Ms. CUSHMAN. In many areas, there are agencies with United Way support or with public support from municipalities that certainly helps these clients receive necessary care. We are experiencing the need for the increased coverage from those sources is outstripping even the availability of public charitable contribution funds.

Mr. FROST. I don't mean to dwell on this subject. I have a personal interest in this matter because I, personally, experienced this situation, and that does give you a greater appreciation for the needs and the role of home health care.

Ten years ago, my wife contracted cancer and chose to die at home, and spent the remaining last month of her life at home and was cared for by round-the-clock care. So I have some personal acquaintance with this matter.

Let me ask you all some other questions regarding the way the PPS system has operated. You have all touched on this in terms of the early release.

Is that inevitable in the system as it has been constructed? Is there any way that that can be dealt with, that patients would not be released too soon and too sick, as you have all testified?

Mr. WILLGING. What I have testified to, Mr. Chairman, is not that they have been released too soon or too sick, but that they have been released quicker and sicker. I think too soon and too sick depends upon the capacity on the other side of the equation, whether it be home care or nursing home care. Patients being released too soon and too sick is relevant if there are no providers of care who can handle that patient at the increased level of acuity when they are discharged from the hospital.

So in a sense we have testified to the fact that it is too soon and too sick, but only because the nature of the system does not allow skilled nursing facilities, as in my case, or home care agencies, as in the case of my two colleagues, to provide the kind of care required in terms of the reimbursements allowed, the kind of decisionmaking process that we are going through.

I think it is clear that when the system was devised it was done so to allow for earlier discharge; otherwise, it would not be the cost-saving mechanism that Congress had in mind when it was first enacted.

Mr. FROST. That does put a greater burden on your agencies.

Mr. WILLGING. Absolutely. And I think we are all discovering that.

Mr. FROST. Either one of you want to make any comment on that?

Ms. CUSHMAN. I would second the comments that the gentleman has made. I think that the biggest problem for us is the inadequate reimbursement for the very sick patient. We are repeatedly told that the home care benefit was not designed to take care of patients that are sick, and therefore the administration has consistently applied decisions that say that that type of patient simply should not have that care reimbursed at home.

Ms. FISHER. I think this raises philosophical and ethical issues. The fact is that these people are in the community. However, it is also a fact that you have limited community resources. What can you do to try and provide the necessary care to patients who do not have coverage for these services? Frequently, we try to stretch your resources to cover it and thereby defeat ourselves by appearing able to provide these services within our limited resources.

So I don't know what the answers are. I know that staff are really stretched trying to work with these situations. And I have concerns that it is at the cost of other programs such as maternal health, and child health programs that we are trying to care for this particular medicare population.

Mr. FROST. Let me ask you a related question. If we were to freeze DRG payments for another year, if the administration comes forward and asks us to freeze DRG payments for fiscal year 1987, as well as freeze for fiscal year 1986, is this going to put even more pressure on your agencies, or are we likely to see patients being released even more quickly than they are right now?

Mr. WILLGING. My sense is that it should not do that, although it may cast some financial pressures on the hospital. But I do believe, to a considerable extent, that there is still a professional, moral ethic at work within the hospitals where they will not be released prematurely. They may be released as early as they are today, perhaps as sick as they are today, but I have not seen other than a few isolated cases of anecdotal information that essentially we were dumping patients out of hospitals.

I know there has been some reference to that over the course of the past year or so. I haven't really seen this. I think the problem is serious enough today without our having to worry whether it will get even more serious a year or 2 or 3 years down the pike. It is serious enough that it warrants solutions today.

Mr. FROST. Either one of the others?

Ms. CUSHMAN. I would anticipate similar results with the exception that, as hospitals are forced to contain their costs even more, services such as discharge planning for smooth coverage in the home, and even perhaps their staffing levels in the hospital which might enhance their ability to teach patients more while they were there, or provide additional care, simply will be reduced.

Ms. FISHER. Again, if only a few people are dumped in the community, it still is quite a stress to those people and their families, and I do think some of that does occur. I don't think it is a major occurrence, however, but the effect is still very real on the people it does happen to.

Mr. FROST. Well, I don't have any other questions. This has been very interesting. I appreciate your testimony. The hearings have been extremely interesting.

We will be receiving the President's budget in January or early February of next year. Depending upon the amount of time that the full Budget Committee has to consider that budget, I know this task force will be very interested in the recommendations and comments of various people in the medical community about the proposals that the President and the administration will make for fiscal year 1987, and we may well be asking some of you to make comments either in person or in writing.

We appreciate all of your testimony and your interest in this proceeding.

Thank you very much.

[The following additional material was submitted for the record:]

REMARKS OF HON. VIN WEBER ON THE HOUSE BUDGET TASK FORCE ON HEALTH HEARINGS ON MEDICARE AND THE PROSPECTIVE PAYMENT SYSTEM

The testimony presented by the various experts on Medicare's Prospective Payment System (PPS) was thorough and insightful. I now have a much better understanding of the many problems the Federal Government, the medical community and the recipients face.

The task force's chairman, Rep. Martin Frost, deserves to be commended by his colleagues on the Budget Committee for his adept handling of these hearings. I am proud to be associated with his efforts on this committee. He is without question a conscientious and knowledgeable member.

Although we have heard balanced and ample testimony on the positive and negative aspects of the PPS, the changes we can make as a committee are very limited. Our task should be to find what savings, if any, can be achieved in this area.

This committee should be concerned with the larger issues of the future financial integrity of the Medicare system. Problems are experienced by those who are involved with PPS on a daily basis. The testimony makes this clear. But, I feel we as a committee must deal with the questions of lessening or increasing government control, solvency of the system in the years 2000 and beyond, and what economic consequences our actions will have on future generations.

Let me outline two general recommendations:

1. Future savings can and must be achieved.
2. There must be a fundamental restructing of the way the government provides health care.

The Medicare program is pay as you go. If you raise benefits you must increase taxes to pay for those benefits. Likewise, if eligibility increases, either benefits must be cut or taxes must be increased. The system, by virtue of demographic shifts, will experience a rise in eligibility perhaps within 10 years. Under virtually any realistic scenario, the hospital insurance fund will be unable to meet its obligations. The Board of Trustees for the hospital insurance fund (HI), have stated that in order to bring the program even close to actuarial balance during the next 25 years, either outlays will have to be reduced by 19 percent or taxes increased by 24 percent. They note further that during this period slightly more than two workers will be supporting each recipient.

Raising taxes or slashing benefits by those drastic amounts is unacceptable.

If our committee does not act to meet the challenge now, we face the dilemma of virtually enslaving our children to endless tax increases or denying certain types of care to the ill.

The only way to avoid this collision between generations is by gradually reducing costs now so the HI fund can build the necessary reserve to meet the shift in demographics or the loss of revenue due to unforeseen economic problems.

It is a fact that the HI fund will be depleted. Our committee can face that reality by immediately moving toward fiscal restraint. However, that's only half of the equation. Merely making marginal changes in the system will only delay the possibility of collapse.

The Federal Government must deliver health care services to Medicare recipients more efficiently. If we explore fundamental changes in health care delivery we can succeed in our fiscal responsibility to future generations and our fiduciary responsiblity to the present generation.

When we convene to address the fiscal 1987 budget, I hope the full committee looks at the testimony gathered by the Health Task Force and acts to reduce Medicare spending so the system will be solvent in the future.

PREPARED STATEMENT OF DONALD F. REILLY, DEPUTY EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON THE AGING, INC.

Mr. Chairman, my name is Donald Reilly. I am the Deputy Executive Director of the National Council on the Aging, Inc. NCOA is verypleased that the subcommittee is examining the impact of the Medicare prospective payment system (PPS). Since there were no Congressional hearings by the legislative committees prior to enactment, a thorough review of the plusses and minuses is quite timely. The system was introduced in 1983 to curb the skyrocketing costs of health care for older persons. These costs were to be controlled by providing hospitals with a set advance payment for each type of case an elderly patient represented -- each case being pigeonholed into one of 468 "diagnosis-related groups" or DRGs. Since the hospital is reimbursed a predetermined amount, regardless of the length of the patient's stay, powerful incentives have been created for a hospital to discharge patients as early as possible.

The data shows that hospital stays for patients under the DRG system have dropped by more than 20 percent. But, it remains to be seen whether these early discharges are appropriate because doctors may previously have been too conservative in their care and inappropriately retained elderly patients, or whether the new system encourages the discharge of patients "quicker and sicker" as concluded by a recent General Accounting Office preliminary report.

The National Council on the Aging (NCOA) believes that a prospective payment system for health care is necessary for cost control, not only for older people, but for all Americans. Further, we believe that prospective payment can eventually be expanded to cover a broader range of care, including the community-based services that older people require following discharge. The core issue, however, is how to impose the discipline of cost control without any erosion of the quality of care. NCOA welcomes the opportunity to assist the subcommittee in identifying flaws in the current system and proposals for improvement.

There must be an urgency to this review. We are concerned that older persons and their families may be severely suffering as theyplay out the guinea pig role to which they have been assigned by virtue of being old and sick at a time when 20 year old social policy (quality health care for older persons as a right) is being significantly modified. We understand and agree with the need for improvements in the health care system. Indeed, the movement away from a bias that more care is necessarily better care is long overdue. But there has been a lack of sound ecological planning in the proposed change -- inadequate recognition that altering one aspect of the health system would impact other aspects, and disregard of the cost displacement consequences that would necessarily result.

Our members report the following as some of the critical consequences that have resulted from the implementation of the prospective payment system:

- Doctors and hospitals are choosing to shift responsibility for medical decisions to Medicare and the DRG system. Patients and their families are being told "Medicare won't pay for any more hospital days. Your Medicare benefits have run out." The DRG length of stay was intended to be an average. In some cases it has been taken as a maximum so that the hospital accepts none of the risk, putting it all on the patient.
- Patients being discharged are more dependent and an increasing number require intensive nursing care at home for such services as hyperalimenation and chemotherapy. These services require 3-4 hours of nursing care per 24 hours, yet Medicare will reimburse home health agencies for only one hour of RN care per 24 hours.
- Families and others responsible for care of discharged patients are confused and frustrated by the lack of available community services and when available, the Catch 22 (or Catch 65) reimbursement policies, which will reimburse only for medications provided in the hospital or will cover insufficiently for home nursing care necessary because of early discharge of the

patient from the hospital.

- Patients without family, or with no appropriate caregiver (e.g., a 90 year old patient whose wife is 87 and also quite frail; or a childless patient in her 80s whose husband has Alzheimer's disease), are all too frequently discharged with no consideration given to the fact that there is no one at home available to care for them.
- Discharge planners are overloaded and unable to plan adequately for the care of each patient to be discharged. In some instances, patients are being channeled into skilled nursing facilities when -- if community-based case management and other supportive services were available and organized by the discharge planner -- they could have remained at home.
- Some "for profit" home health agencies are accepting referrals but are subsequently unable to deliver services; some are "using up" the patients Medicare benefits and then denying the patients continued service. These patients then turn to non-profit home care agencies which tend to serve them, but are burdened with the need to raise money to cover the costs of delivering these unreimbursed but necessary services.
- There is far too little recognition in implementing DRGs of the special characteristics of elderly patients which complicate any standardized application of rigid

hospital admission or discharge policies. These include slower recovery times, idiosyncratic responses to medications and other therapies, the likelihood of mental agitation and confusion and the possibility of transfer trauma.

- The study of the impact of prospective payment and DRGs has been too focused on hospital discharges while too little attention has been given to the impact of these hospital discharges on community services and family caregivers. The Southwest Long-Term Care Gerontology Center surveyed Area Agencies on Aging to get an initial determination of the scope of impact. They found a 365% increase in case management services, a 196% increase in in-home skilled nursing, a 69.2% increase in housekeeping services and a 30-35% increase in home delivered meals. Area agencies on aging whose Older Americans Act funding has been frozen at current levels can only meet those demands by decreasing the units of service received by each client, passing along the costs to the clients and reducing the preventive services the agency otherwise might fund. The Center's study also reported that inadequate family support contributed to 49% of the hospital readmissions.

- There are reports that overall hospital profits have increased since the implementation of DRGs, and that the reduced length of hospital stay has been primarily among the elderly; both of these findings suggest that detrimental affects of the prospective payment system are borne by older persons and those caring for them, further supporting the need for a prospective payment system to be expanded to include all hospital patients.

What is truly needed is a nationwide systems approach to health care, which deals with the entire spectrum from health promotion and preventive services on one end, through ambulatory and hospital treatment for acute care needs, to a comprehensive non-means tested system of community long-term care at the other end. In other words, this nation needs a federally sponsored universal health insurance plan. Until we reach that point, we will continue to only deal with parts of the system. Thus, while trying to make repairs in one area we will often inadvertently create new problems in other areas of the system.

This is what has happened with Medicare hospital prospective payment. Cost containment policy requires a larger view than simply focussing on a single age cohort.

However, NCOA has recommendations for improving the current system. They are as follows:

- A severity-of-illness index should be factored into the DRG categories.
- A factor to compensate hospitals that disproportionately treat the poor should be factored into the DRG categories.
- The Health Care Financing Administration (HFCA) should be required by law to produce a patient-consumer oriented booklet which explains how the prospective payment system is designed to work, how it relates to discharge from the hospital, and what rights of appeal exist; and require that each hospital provide the booklet to each Medicare patient prior to admission.

- HFCA should require that each hospital produce a booklet which explains its discharge planning process for Medicare patients, and issue the booklet to each Medicare patient prior to admissions.

- Medicare conditions of participation for hospitals should include a requirement that hospitals periodically survey and document the availability and adequacy of community services for elderly dischargees as part of their discharge planning.

- More funding for home care, adult day care and other family caregiver respite services should be made available through the Older Americans Act and Medicaid.

- The Medicare homebound definition should be broadened to permit a mix of in-home and community group program services, such as adult day care.

- The Long Term Care Ombudsman program under the Older Americans Act should be expanded to cover the discharge from hospitals of Medicare patients who require additional health care or supporting services.

- Prospective payment should be extended to cover all hospital patients in order to preclude a two tier system of care.

- HCFA should be directed to fund a series of continuing studies of the outcomes of the prospective payment system with regard to cost savings; cost displacement to Medicaid, Older Americans Act programs, privately funded services, and patients; and on the quality of care during the hospitalization and after discharge.

In closing, NCOA wishes to affirm the basic approaches of the Medicare prospective payment system experiment, while we urge prompt action on remedies for its flaws. We encourage a broader view which looks at health care of older persons as a system, so that the whole range of services critical to the health care of older persons is included, not merely those delivered in the hospital or under very stringent medical supervision. We believe that a health care system directed to older persons needs to recognize the interrelationship and costs of four other areas in addition to acute hospital care:

1) the role and limitations of family in providing care and the need for those without family to be able to access equivalent care.
2) the growing number of services designed to augment or substitute for family support and to provide family respite -- friendly visitors, senior centers, adult

daycare programs, and other community-based efforts.

3) the key function of home health and home care services in rehabilitation and maintenance efforts.

4) the increasing role of the nursing home for intermittent "heavy" care as well as long term maintenance care.

Health care for the elderly must be viewed as a continuum of health and social services ranging from those provided in institutional settings to those provided in community-based facilities to those provided in an individual's own home. We believe both federal programs and private insurance must cover services such as adult day care, home health, respite care and homemaker assistance, because these services are often best suited to meeting the care needs of an elderly person while allowing that person to remain in the supportive and familiar environment of his or her own home.

Thank you, Mr. Chairman, for permitting me to share our views with the subcommittee.

(A Survey by the American Society of Internal Medicine, March 1984-October 1985)

BACKGROUND

Following implementation of Medicare's prospective pricing system in 1983, ASIM initiated a number of activities designed to familiarize internists with this new payment mechanism and to assess its impact on patients and hospital/medical staff relationships. ASIM recognized that the provision of quality patient care would take on even greater importance under a prospective pricing system based on DRGs, and, consequently, in March 1984, authorized funds for the design and distribution of a survey to evaluate the effects of DRGs on patient care.

ASIM's survey on DRGs and patient care first appeared in the March 1984 issue of The Internist (see Attachment A). Since then, it has been offered to members through the Society's newsletter and distributed at component meetings on an ongoing basis. The primary purpose of the survey is to evaluate the effects of the PPS system--both positively and negatively--on the quality of patient care. Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration (HCFA) any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

Although not a scientific survey, this project has successfully reached a substantial number of internists and elicited informative responses. As of mid-September 1985, 246 ASIM members, representing broad-based internists, subspecialists of internal medicine and neurologists, completed the survey. Many have submitted lengthy letters and case reports documenting specific instances where they believed DRGs had negatively affected patient care.

SURVEY RESULTS

The survey results are summarized below under five general areas: Quality of care, severity of illness, PRO review, changes in hospital practices/services, and hospital/medical staff relations.

1. Quality of Care

In its survey, ASIM asked internists whether they believed that the DRG system had improved the quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved and utilization review programs, improved communication among hospital departments). Only 24 of the 246 respondents noticed an improvement in the quality of care provided to Medicare patients. Moreover, there were over 200 specific reports of incidents in which internists believed the quality of care had been compromised as a result of DRGs.

The most common of these, reported by 105 internists, was the premature discharge of patients due to perceived DRG-related, hospital-imposed pressures. The following comments from individual internists are illustrative of many of those received:

> "Printed forms appear on the chart 1-2 days before the DRG expires strongly suggesting discharge."

> "The overall thrust of communications from the (hospital) administration is towards early, perhaps inappropriate, discharge."
>
> "When the DRG 'expires' I am reminded and urged to do something."
>
> "Pressure to discharge sooner is very great and workup is often incomplete."

Many internists also reported receiving daily updates or notices on how much their hospitals were losing as a result of certain patients. There were also indications that these pressures are being communicated to patients. As one internist commented:

> "One local hospital details the cost on the front of the record--the patient is aware of this. It has created anxiety . . ."

The remarks of other internists imply that the pressure many of them are experiencing to discharge patients earlier may be more indirect:

> "The hospital is not exerting pressure on our staff, but there is pressure just knowing the hospital's livelihood depends on us."

Many internists gave specific examples of the types of patients they believed were being discharged earlier than medically appropriate:

> "Alzheimer's patients without good placement."
>
> "Patients with pneumonia and abdominal pains."
>
> "Stroke patients have been transferred to inadequate intermediate care facilities because they had the first bed available."
>
> "Patient with prolonged problems with deep vein thrombophlebitis. (Another) patient with pneumonia went home before completing antibiotic course. Both patients were readmitted."
>
> "A post-cholecystectomy patient age 82 who had a collapsed vertebra, could hardly walk, and was not eating properly."
>
> "I could give you at least 50 examples already. Most patients were in the cardiac and chronic obstructive pulmonary disease (COPD) classes."

In a related question, internists were asked whether there had been any increase in patient mortality or morbidity associated with premature discharges. Some 47 respondents agreed that in their opinion early discharges had led to increases in patient mortality or morbidity, with many offering their specific impressions and experiences:

> "I feel so, at least two medical fatalities might have been avoided."
>
> "One patient with leukemia died at home three days after a premature discharge."
>
> "Definitely. A patient did not meet the criteria for further stay. He died a few weeks later."
>
> "Increased morbidity but not mortality as yet, although expected in the future since the hospital will get stricter in its evaluation."

Internists were also asked whether they had experienced any pressure from their hospitals to discharge patients and readmit them within the next few days or weeks, or were aware of instances where this had occurred. Eighty-one internists complained about hospital pressure to readmit patients shortly after discharge. Subsequent readmissions have two implications regarding quality of care, as evidenced by the responses. First, many internists stated that a large portion of these readmissions were the result of premature discharges: the patients were not strong enough to leave the hospital and suffered relapses. A gastroenterologist recalled one such instance:

> "EM, a 70-year-old black female, was admitted to the hospital and discharged one week later. She had diabetes, cholelithiasis, weakness, and difficulty in taking care of herself. Additionally, arteriosclerotic heart disease was a problem. She was dizzy and also had peptic symptoms.
>
> On the last hospital day after she was seen on medical rounds, she decided not to have a cholecystectomy. The hospital called my office and said since she had made the decision, and since she was a 'DRG patient,' 'can she be discharged?' Under those conditions and in spite of the fact that I felt she needed medical supervision and several days more in the hospital for general care, regulation of diabetes, and further assessment regarding gall bladder and cardiovascular problems, I agreed to the hospital's request.
>
> This was a mistake. She was readmitted to the hospital some 12 hours later having had a 'black-out' spell at home, which probably represented a transient ischemic attack.
>
> It was probably my error in submitting to pressure to get the patient out of the hospital earlier."

Secondly, regarding complicated hospital stays, internists reported that hospitals have been encouraging them to discharge patients and to readmit them at a later date for treatment of a second condition they had diagnosed during the first stay. As several internists reported:

> "We're advised if patients are found to have multiple problems, handle one major problem per admission."

> "Patients with multiple medical problems have one problem primarily dealt with per admission."
>
> "We are made well aware of the 'rules' encouraging this."

One respondent described a case in which a patient with old pulmonary tuberculosis and supporative bronchitis was diagnosed as also needing cataract extraction. After the patient's course of IV antibiotics, the hospital wanted her discharged and readmitted for cataracts. Another respondent spoke of a similar case but with a more drastic end: the patient was discharged, and kept out of the hospital for one week in order to be readmitted under a new DRG; the patient then died during the second readmission.

Finally, internists were asked whether they'd experienced pressure to underutilize medically necessary tests and procedures, and if so, to cite specific tests and procedures that they believed were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity. Only 35 out of a total of 246 internists responded affirmatively to this question. In fact, more internists (83) believe that DRGs have had the salutary effect of promoting a decrease in the ordering of unnecessary tests and procedures. However, a number of internists expressed concern that DRGs could eventually lead to underutilization of certain tests and procedures, to the detriment of patient care. In the words of one internist:

> "In my opinion, the single most important reason that 'unnecessary' tests are run is fear of lawsuits. When MDs can stop being afraid they will be sued if they miss some exotic, rare disease, they will stop ordering so many tests. I am afraid that the DRGs will pressure physicians to avoid tests because they aren't cost effective and legitimate diagnoses will be missed, leading to an increase in lawsuits. I think that one of the bad aspects of DRGs is that we cannot look for unusual disease entities because in general these searches are expensive and often nonproductive, and will be looked upon by PRO committees, etc., as inappropriate."

2. Severity of Illness

Internists were asked whether there were any DRGs they believed should be revised because they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degrees of patient illness, given the same diagnosis. Almost half of the respondents (102) indicated that changes needed to be made to either some or all of the 468 DRGs to adequately reflect variations in severity of illness. As one member summed up:

> "I feel the biggest problem seen so far is that the DRG is unrealistic--patients often have several diseases which need evaluation and/or treatment but DRGs relate to only one diagnosis. That means either poor care or cost overruns."

Of the DRGs specifically mentioned as needing revision, these cases were repeated most frequently: Guillian-Barre's syndrome, respiratory failure, myocardial infarction (MI), cerebrovascular accident (CVA), leukemia, chronic obstructive pulmonary disease (COPD), and stroke. The major complaint against the code for respiratory failure was that it does not allow for variations in condition and response. The DRGs for MI, CVA, and COPD lack flexibility to account for outside variables and complications.

Physicians stressed the need for severity classifications as some cases require more hospital days than others. Respondents complained about the inadequacy of the DRG for leukemia to pay the cost of services as it underestimates the necessary amount of care. Internists commented specifically on such inaccuracy:

> "The length of stay allowed for acute leukemia hospitalization is less than ten days, yet a course of remission induction chemotherapy typically requires 25-35 days."

> "Continuous IV infusion for seven to ten days is standard for a diagnosis of acute leukemia (DRG 404), and the DRG allows nothing for this or usual complications."

The DRGs for strokes presented problems because all strokes are, as one internist phrased it, "lump(ed) into a few simplified categories;" variations and complexities of strokes are not accounted for.

Some 75 internists reported experiencing pressure from their hospitals to upgrade the severity of diagnoses in order to maximize reimbursement. Respondents stated that many hospitals educate physicians through lectures and posted reminders to, for example, "seek more proper categorization to obtain maximum payment." Others reported that:

> "(We're) told to list all possible diagnoses so the best ones can be chosen."

> "There are DRG lists on all floors. The medical records people are always 'negotiating' our discharge diagnoses with us."

> "Diagnosis terminology is changed to fit the computer program. No change in 'severity'."

> "If you want to stay with the hospital you probably have to do that since the hospital is a business and the administrators always look at dollar figures."

3. PRO Review

Approximately 56 respondents stated that they believed the hospital's designated medical review agent (PRO or in the absence of a PRO, a fiscal intermediary) had increased its denial of medically indicated admissions under DRGs, to the detriment of patient care. As several members commented:

> "Dependence upon criteria is too strict."

> "Borderline cases are turned down, but usually are revised on appeal--MDs are more careful. But what about the patient who needed care but is borderline, as is the elderly man with pneumonia who lives alone?"

> "I am sure that some patients are not admitted because of possible denial."

> "I've had two patients denied despite the fact they needed admission, in our first three months of DRGs."

Some 45 internists also indicated that the PRO or fiscal intermediary had denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare.

4. Changes in Hospital Practices/Services

ASIM sought internists' views on whether the implementation of the DRG-based system has led to any decrease in the quality of services provided by hospitals such as (1) short staffing; (2) inappropriate substitution of nonbioequivalent generic drugs for brand name drugs; (3) a decision not to install a technologically advanced piece of equipment that has the potential to improve patient care; and (4) a decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere.

In response, 104 internists reported short staffing of, for example, nurses or lab technicians in their hospitals. They reported many lay-offs of nursing staff, resulting in increased paperwork and errors; decreased RN status and increased use of aides; decreased night coverage and delays in lab tests; and less nurses per patient. One internist reported not having "enough nurses to carry out tasks. A typical patient comment: 'I asked for a pain pill three hours ago."

Although not to as great an extent, ASIM members also noted the inappropriate substitution of non-bioequivalent generic drugs for brand name drugs (28 physicians); more decisions not to install a technologically advanced piece of equipment that has the potential to improve patient care (55); and decisions not to treat certain types of illnesses, or the encouragement of physicians to admit these patients elsewhere (43).

5. Hospital/Medical Staff Relations

A substantial number of internists spoke positively about hospital/medical staff relations. Three-quarters of the total number of respondents observed an increased awareness of medical costs among the staff. Some physicians commented that this consciousness of costs has heightened at the expense of quality care; for example, some argued that length of stay is shortened and the more costly and complicated tests are not implemented to the patient's disadvantage, or diagnosis/treatment of the more obscure illnesses is excluded. However, the general opinion is that this awareness is positive, as more physicians are becoming involved in various discussions and programs aimed at minimizing health care costs.

Forty-two respondents believed that the relations in general between the hospital and medical staff have improved. They've noticed increased participation and cooperation, and overall, better interaction between hospital and medical staff.

On the other hand, forty-two ASIM members complained about hospital efforts to identify and deny or restrict privileges to physicians perceived as "too costly." A more substantial number of respondents commented that although this has not been fully witnessed at this time, they can see such actions developing. Some have stated that the identification process--through so-called DRG profiles--has already begun, and that it is only a matter of time before outright denials are made by the hospital administration.

SUMMARY OF KEY FINDINGS

ASIM's survey results have documented both positive and negative experiences, opinions, and concerns of internists from across the country, and while anecdotal, provide some insight into the system's effects on physicians, patients and hospital/medical staff relations. As evidenced from the responses, many internists agree with the cost-saving potential of the prospective pricing system but are concerned that cost reductions will occur at the expense of patient care. Those responding to the survey clearly viewed pressures to discharge patients early as detrimental to the quality of patient care. This finding corroborated that of a study on DRGs conducted earlier this year by the General Accounting Office (GAO). The GAO found that patients are being discharged from hospitals after shorter lengths of stay and in poorer states of health than prior to DRGs. Many patients are being told improperly that they have to leave the hospital because their Medicare/DRG coverage has run out, according to the study.

Many internists responding to ASIM's survey recommended that adjustments be made to the DRG system so that it would better reflect variations in the costs of caring for certain patients. The average length of stay given in the Federal Register for each DRG was considered inappropriate for the following cases: Guillian-Barre's Syndrome, MI, CVA, COPD, leukemia, respiratory failure, and stroke.

FUTURE ASIM ACTIVITIES

ASIM will continue to survey members on an ongoing basis in an effort to evaluate the effects of DRGs on patient care. In addition to the ongoing survey, a more scientific survey will be conducted of a random sample of ASIM members. The Society will share these and future results with Congress, HHS, and PROPAC (Prospective Payment Assessment Commission), recommending changes to the system as appropriate.

The data received will enable ASIM to evaluate the system and propose any necessary changes. At this point, the Society has identified the major areas of concern and will continue further study in order to determine:

1. Whether or not the DRG-based system adversely affects the quality of medical care by limiting length of stay and results in the deterioration of the quality of hospital practices.

2. Whether or not DRGs decrease the accessibility of care by encouraging hospital review entities to deny certain admissions.

3. To what extent reimbursements are inadequate under the system and what the long term consequences are.

/srl
L-9001B

Total number of respondents--246

Special Survey

ATTACHMENT A

How Have DRGs Affected Patient Care?

As all physicians know, a Medicare pricing system for hospital services based on diagnosis-related groups (DRGs) is now being implemented across the country, effective with the start of each hospital's fiscal year. This system is intended to encourage hospitals to become more cost efficient than has been the case in the past, and thereby to reduce the rate of increase in federal health expenditures.

ASIM is interested in collecting data with which to evaluate the effects of this system—both positively and negatively—on the quality of patient care. To do so, we need the help of internists—both ASIM members and nonmembers. If you are an internist or a subspecialist of internal medicine and have personally experienced any instances where the DRG system has affected the quality of inhospital care provided to Medicare beneficiaries, please complete the questionnaire below and return it to ASIM. To protect yourself and ASIM, please *do not* name or otherwise identify any patient, other physician, hospital, its management or personnel. Use *generic* terms only.

Based on the responses received, ASIM will evaluate any trends that seem to be occurring nationwide and will communicate to Congress and the Health Care Financing Administration any changes that should be made to the DRG system (for example, recalibrating DRG weights or increasing the number of DRGs).

There is no deadline for submission of this form since all hospitals are not yet under the DRG system; rather, we would like you to make copies, completing and mailing them to ASIM as the need arises. In addition, please feel free to make copies for other internists—ASIM members or nonmembers (e.g., in your practice or at hospitals).

Please answer the following questions based on your personal experience under DRGs, being as specific as possible in your response. Where appropriate, give examples of particular instances where the care of a patient has been affected, either positively or negatively. Including specific information related to each patient—age, sex, diagnosis, DRG assigned to the case, length of stay—would enhance the value of this questionnaire in establishing credible data with which to evaluate the DRG system. (Use additional sheets of paper as necessary.) PLEASE TYPE OR PRINT.

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1. As a result of DRGs, have you experienced any pressure from your hospital to do any of the following—or been aware of instances where these problems have occurred (please check all those that apply):

☐ Discharge patients earlier than medically appropriate. (Please explain specific circumstances.)

105 responded affirmatively

☐ If so, has there been any increase in patient mortality or morbidity associated with premature discharges? (Please explain.)

47 responded affirmatively

☐ Increase short-stay admissions. (Please explain.)

48 responded affirmatively

☐ Underutilize medically necessary tests and procedures. (Please cite specific tests and procedures that you believe were indicated given the patient's condition but were not provided, and any effect that underprovision of these tests and procedures may have had on patient mortality and morbidity.)

35 responded affirmatively

☐ Discharge patients and readmit them within the next few days or weeks. (Please explain.)

81 responded affirmatively

☐ Upgrade the severity of a diagnosis to maximize reimbursement (i.e., "DRG creep"). (Please explain.)

75 responded affirmatively

☐ Other. (Please explain.)

35 responded

2. Are there any particular DRGs you believe should be revised because, for example, they do not reflect the actual resources used to care for a patient or they do not account for variations that exist in the degree of patient illness, given the same diagnosis? (Please explain, giving relevant DRG codes.)

102 responded affirmatively

3. Has the implementation of the DRG-based system led to any decrease in the quality of services provided by your hospitals such as:

☐ Short-staffing (e.g., of nurses or lab technicians). (Please explain.)

104 responded affirmatively

☐ Inappropriate substitution of non-bioequivalent generic drugs for brand name drugs. (Please explain.)

28 responded affirmatively

☐ Decision not to install a technologically advanced piece of equipment that has the potential to improve patient care. (Please explain.)

55 responded affirmatively

☐ Decision not to treat certain types of illnesses, or encouragement of physicians to admit these patients elsewhere. (Please explain.)

43 responded affirmatively

☐ Other. (Please explain.)

10 responded

4. Has the hospital's designated medical review entity (professional standards review organization (PSRO), peer review organization (PRO) or fiscal intermediary):

☐ Increased its denial of medically indicated admissions under DRGs, to the detriment of patient care? (Please explain.)

56 responded affirmatively

☐ Denied care previously considered medically necessary under the cost-plus reimbursement system and therefore covered by Medicare? (Please explain.)

45 responded affirmatively

☐ Other. (Please explain.)

13 responded

5. *Do you think DRGs have led to:*

☐ Increased cost awareness on the part of the medical staff? (Please explain.)

183 responded affirmatively

☐ A decrease in the ordering of unnecessary tests and procedures? (Please explain.)

83 responded affirmatively

☐ Improved relations between the hospital and medical staff? (Please cite specific examples.)

42 responded affirmatively

☐ Efforts by the hospitals to identify and deny or restrict privileges to physicians perceived as "too costly?" (Please explain.)

42 responded affirmatively

☐ Improved quality of care provided to Medicare patients (e.g., by encouraging more careful ordering of tests and procedures, initiating improved quality assurance and utilization review programs, improved communication among hospital departments, etc.)? (Please explain.)

24 responded affirmatively

Hospital Classification: ☐ Urban; ☐ Rural

Hospital Type: ☐ Community (nonprofit); ☐ Private (for profit); ☐ Teaching; ☐ Other (please specify) ________

Bed Size ________

We have purposely left the responses anonymous to ensure greater candor in the replies. If you wish to identify yourself, however, please feel free to do so.

Internal Medicine Subspecialty (if any) ________

Date ________

PLEASE RETURN TO:

american society of internal medicine
1101 Vermont Avenue NW Suite 500 Washington DC 20005

PREPARED STATEMENT OF HON. JAMES ROOSEVELT, FORMER CONGRESSMAN AND CHAIRMAN, ON BEHALF OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

The National Committee to Preserve Social Security and Medicare now represents over 1.5 million members nationwide, most of whom depend for their lives on the medical protection afforded by Medicare's hospital insurance program. We are concerned that the push to contain health care costs through prospective payment in Medicare is exacting too high a price in terms of poor quality care for many elderly beneficiaries. We hope that the ample evidence on the effects of prospective payment gathered during these Health Task Force hearings will convince Congress and the Administration not to allow cost-cutting in Medicare to shortchange the millions of medically-needy, elderly beneficiaries the program was designed to protect.

Medicare's prospective payment program was enacted in 1983 with an eye toward reducing the size of government payments to hospitals and promoting quality care. Up to now, the former goal—cost containment—has apparently assumed priority. There are signs that this cost-consciousness may be making a difference. Last year, medical care spending dropped below double-digit levels for the first time in two decades, in part because of prospective payment, and the average hospital stay for Medicare patients fell about two days since 1982.

Like many prescribed cures, unfortunately, cost containment in Medicare has its own share of negative side effects. There is increasing evidence that hospital providers, pressured to reduce costs, are opting to cut corners—by refusing to admit some Medicare beneficiaries, by discharging others too soon "because the DRG ran out," by ignoring multiple serious conditions, or by forcing patients to undergo a debilitating admission/readmission cycle in order to piece together payment for the full range of needed care. This problem is made worse by the lack of adequate post-hospital facilities in the community to care for those seriously ill patients who have been inappropriately or prematurely discharged from the hospital, and who live alone without nearby family to care for them.

The pressures of this cost-squeeze not only endangers the health and lives of our Seniors. Just as disturbing is the fear and anxiety that such a system engenders in older people who, rendered vulnerable by serious illness, are left uncertain about how their immediate health care needs can be met.

The National Committee believes that efforts to contain health care costs will ultimately fail unless these distressing negative side effects are eliminated from the prospective payment system. We recommend that Congress and the Administration take the following actions to strengthen the prospective payment system to meet Medicare's goal of affordable, quality health care for our nation's elderly.

PERMIT ANNUAL HOSPITAL RATE INCREASES

Hospital prospective payment rates were scheduled to be adjusted upward annually in 1986 to reflect increased medical inflation and other factors. The recent decision of Congress and the Administration to limit the 1986 increase to 1 percent or less was driven by budget constraints that have little to do with establishing the groundwork for an effective health cost containment program. This near-freeze on prospective payment rates will create severe problems for those hospitals already struggling to keep costs down, or may eventually cripple the system before it has a chance to mature. More seriously, the budget squeeze on Medicare will discourage hospitals from admitting elderly patients—or encourage them to lower their quality of care.

The National Committee hopes that Congress and the Administration will not continue this freeze on hospital reimbursement rates in the fiscal 1987 budget.

ADOPT A "SEVERITY OF ILLNESS" INDEX

Many problems with prospective payment would be alleviated if Congress enacted a classification index that reflects degrees of medical complications within the specific diagnosis related groups (DRGs). A severity of illness index would enable hospitals treating very sick patients to be reimbursed for more intensive care. Presumably, this fine-tuning of the system would also result in hospital cost-savings, in cases where a patient has relatively few complications and requires minimal treatment under DRG stated guidelines.

STRENGTHEN PRO REVIEW AND APPEALS PROCESS

The PRO program which monitors Medicare for the government has up to now focused efforts primarily on cost containment. We believe that there is an urgent need for PROs to play a more active role in monitoring quality of care—particularly aimed at the appropriateness of discharges. PROs should also be charged with the responsibility to deny payment to a hospital or physician on the basis of poor quality care.

The time has come for the Health Care Financing Administration to clearly define a workable appeals process by which patients can register their grievances on hospital admissions, discharges and quality of care. All Medicare patients should be informed of their rights under this appeals process. A clear appeals procedure will eliminate much of the fear and uncertainty patients face regarding Medicare coverage. In addition, a well-functioning appeals process will help reassure all of us that, seriously ill Seniors are not falling through the cracks of the newly enacted prospective payment system.

CHANGE INDEXATION OF HOSPITAL DEDUCTIBLES

We support a new method of indexing the Medicare hospital insurance deductible because prospective payment is shifting costs unexpectedly to beneficiaries. While inflation in hospital costs is the lowest in years, the hospital deductible will skyrocket 23 percent in 1986 from $400 to $492. These anomolous results are due to the formula for determining the deductible which is indexed to Medicare's average daily cost for covered hospital services. A reduction in average length of stay has resulted in an overall slowdown in hospital spending even though average daily costs have risen.

We believe that it is possible to operate in an environment of cost containment and still meet the quality care needs of our elderly. The National Committee is committed to working toward that goal.

PREPARED STATEMENT OF CHAD THERAPEUTICS, INC., CHATSWORTH, CA

Mr. Chairman, we appreciate the opportunity to present this statement for the record of the "Task Force on Health" of the Committee on Budget of the United States House of Representatives. We welcome this as an opportunity to discuss a program that has the potential to save the Medicare program over $100 millon per year, and save Medicare beneficiaries an additional $26 milllion per year without adversely affecting patient care or service.

Chad Therapeutics, Inc. (Chad) is a small, publicly owned company, based in Chatsworth, California. Chad was organized in 1982 for the purpose of developing and marketing therapeutically effective medical products, particularly in the area of respiratory care, that would be highly cost effective in this age of health care cost containment. Over the past three years, most of Chad's energies and resources have been directed toward developing and marketing three oxygen conserving products for use in home oxygen therapy.

Home oxygen therapy is provided to Medicare beneficiaries under Part B of the program as part of the Durable Medical Equipment (DME) benefit. Home oxygen therapy, which represents 50% of Medicare's DME costs, is one of the most rapidly increasing cost components of the Medicare program. Acting Administrator C. McClain Haddow of HCFA, in his testimony before this Task Force on September 30, 1985, identified DME as one of two "high utilization items" for which HCFA is seeking improved payment methods. Because of this high utilization, home oxygen therapy is one component of the Medicare program in which significant cost savings are possible.

The American Lung Association, in 1982, estimated that there were approximately 500,000 patients on home oxygen therapy in the U.S. More recently, one expert in this field estimated that there were approximately 1,000,000 patients receiving this therapy. Such an increase in the number of these patients is possible considering that the primary use of home oxygen therapy is for the treatment of patients suffering from COPD (Chronic Obstructive Pulmonary Disease), which is the most rapidly increasing cause of death in the U.S.

The cost of home oxygen therapy ranges from $200 to $1200 per month, and averages between $300 and $400 per patient a month. A major portion of these costs is paid by the Medicare program—indeed, the National Association of Medical Equipment Suppliers estimates that 75% of home oxygen patients are Medicare beneficiaries, for whom the program pays 80% of the costs.

Although HCFA recently has promulgated a number of initiatives aimed at reducing expenditures for home oxygen therapy, none of these attempt to rationalize the use of and payment for home oxygen services, or provide economic incentives for cost savings, efficiency or conservation. Current reimbursement methodologies, which reimburse for the type of equipment and the amount of oxygen supplied, reward waste, inefficiency and over utilization. Indeed, the true economic incentive to home oxygen providers is to provide the piece of equipment that returns the highest rental income and then to supply as much oxygen as possible. The key to maximum provider profitability under current reimbursement methodologies is to provide more expensive equipment and services, and to deliver more oxygen, in order to bill the program as much as possible.

Chad has developed and is actively promoting a program that would rationalize and reduce Medicare's payments for home oxygen therapy. This program would change a provider's basic economic incentives from those discussed above to incentives which reward efficiency, rational utilization, cost control and oxygen conservation.

This proposal calls for Medicare to pay for home oxygen services on a prospective basis by means of an individually calculated monthly capitation fee. Such fee would be determined for each patient individually based on his oxygen requirements as calculated from the physician's prescription. Using data (already required by HCFA) from the prescription, a carrier would easily calculate an individual patient's monthly requirements expressed in total liters required per month. This quantity then would be multiplied by the current local "reasonable charge" for a liter of oxygen, to determine the individual beneficiary's monthly capitation fee. This individualized monthly captiation fee would be the total payment (with Medicare paying 80% and the beneficiary a 20% co-pay), regardless of what type of equipment is provided or how much oxygen actually is delivered.

This type of payment program would provide rational incentives for home oxygen suppliers to provide the most cost effective equipment, promote rational utilization, minimize waste, operate efficiently and conserve oxygen. Logically, as a result of implementing such a program, Medicare's costs for home oxygen therapy should be reduced significantly.

We estimate that the first year's savings from implementation of this program should exceed $100 million for the Medicare program and $26 million for beneficiaries. These savings accrue totally from the elimination of separate rental charges for varying equipment. These rental charges currently average $57.00 a month per patient and are split 80%-20% between the program and the beneficiary.

While the savings that accrue from the elimination of separate rental charges easily are quantified, the potential additional savings that will accrue to the program as a result of shifting financial responsibility for waste and overutilization from the Medicare program to the provider are almost impossible to calculate. HCFA feels that there is currently little correlation between the amount of oxygen purchased and the amount prescribed by the physician. Logic dictates that under current reimbursement methodologies, which provide payment based on the amount of oxygen delivered rather than the amount prescribed, overutilization should exceed underutilization significantly. Therefore, we feel that the changes in provider economic incentives caused by implementation of this program will cause signficant savings to accrue to the Medicare program, in addition to the $100 million per year quantified above.

As evidenced by Mr. Haddow's recent testimony before this Task Force, HCFA is very much interested in reducing Medicare's costs for home oxygen therapy, and strongly supports the entire concept of capitation as a means of reducing health care costs without sacrificing quality. However, at the present time HCFA feels that it lacks the necessary legislative authority to implement a program of prospective monthly capitation fees for home oxygen therapy. A bill giving HCFA necessary legislative authority to implement a program such as we are proposing will be introduced shortly in the House of Representatives. It is our hope that this bill will be made part of next year's cost containment agenda during the budget process.

This proposed legislation has the strong support of the American Association of Retired Persons (AARP), and the American Association for Respiratory Therapy (AART)—which represents over 20,000 respiratory therapists who are the professionals most often involved in oxygen therapy. Additionally, many home care providers—including several major national chains—support this concept as a viable cost control alternative to the various patchwork and punitive cost controls presently being applied.

We feel that this proposal provides a mechanism which will reduce Medicare costs significantly in a humane way, insure the continuation of the home oxygen benefit for the increasing number of beneficiaries who require this life saving therapy, and at the same time do so without jeopardizing the quality of care or punishing the suppliers of this benefit. We sincerely urge consideration of this bill as your Task

Force, the full Budget Committee, and the various committees with jurisdiction over Medicare, consider methods of reducing health care costs.

We appreciate the opportunity to submit this statemnent, and would be pleased to meet at an appropriate time with you, other committee members, and/or staff to discuss this concept further.

AMERICAN FOUNDATION FOR THE BLIND, INC.,
Washington, DC, September 30, 1985.

Re task force hearings on Medicare payment system.

Representative MARTIN FROST,
Chairman, Task Force on Health, Committee on the Budget, House of Representatives, Longworth House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: With great appreciation for your committee's concern for the Medicare payment system, I hope you will share our special interest in the most frequent procedure performed on the Medicare population—cataract surgery—and our six recommendations for cost control, as presented to the Senate Finance Committee during its recently concluded hearings on deficit reduction. We are particularly gratified that four of our six recommendations have now been endorsed by both Senate Finance (see enclosed release) and the House Ways and Means Committees, with the possibility of further endorsement in conference.

If possible, I hope you may incorporate our enclosed statement in your record of hearings.

As the statement indicates, cataract surgery is now the most frequent procedure reimbursed by Medicare. In 1978, 350,000 patients, mostly elderly, had this surgery performed; five years later, in 1983, that number had risen to 578,000; and by the end of this year, the total is expected to exceed 1,000,000 cataract surgery patients.

Since this dramatic increase cannot be supported demographically in terms of overall increase in the elderly population, we are urging that all Medicare-eligible patients be required to obtain a second independent medical opinion before submitting to cataract surgery.

Our other five recommendations are offered with the same dual purpose of patient protection and health care cost control, after reviewing the 3 Federal investigations in this area and subsequent House committee action.

If you require further related information, I hope I may be of assistance.

Sincerely,

BARBARA D. MCGARRY.

Enclosures.

STATEMENT OF BARBARA D. MCGARRY, DEPARTMENT OF GOVERNMENTAL RELATIONS, THE AMERICAN FOUNDATION FOR THE BLIND, BEFORE THE U.S. SENATE COMMITTEE ON FINANCE, SEPTEMBER 11, 1985

As the national voluntary research and consultant agency in the field of services to blind persons of all ages, the American Foundation for the Blind welcomes this opportunity to submit our recommendations on a specific area of deficit reduction already receiving national attention—the issue of skyrocketing costs, both to the patient and to the Medicare program, of cataract surgery.

Because "Cataract surgery is the most frequent procedure performed on the Medicare population in the United States today," in the words of the Inspector General of the Department of Health and Human Services (HHS), we have reviewed the problems presented, the legislative remedies offered, and we summarize our 6 recommendations as follows:

Summary of recommendations:

(1) Before submitting to cataract surgery, a Medicare-eligible patient must be required to obtain a second, independent medical opinion on its advisability and cost.

(2) If medical opinions concur that cataract surgery will be uncomplicated by any pre-existing condition of the patient, Medicare reimbursement should not be available for an assistant surgeon for a routine procedure.

(3) If cataract surgery includes implantation of intraocular lenses (IOL), Medicare reimbursement for such lenses should be within guidelines issued by the Secretary of HHS. For post-cataract patients for whom cataract eyeglasses or cataract contact lenses are prescribed, Medicare reimbursement should be limited to the replacement only once every year of lost or damaged cataract eyeglasses; or, in the first year after surgery, for one original cataract contact lens for each eye, and for the replacement only twice of a lost or damaged lens for each eye. Whatever the method

of replacement for the natural lens, there should be separate determinations of the payment amount for the replacement lens (IOL, contact, or glasses) and of the payment amount for professional services.

(4) Medicare reimbursement for outpatient cataract surgery should be limited to the lower of the amount paid to an ambulatory surgical center or the in-hospital rate under DRG-39 (Diagnosis Related Group for Lens Procedures).

(5) The Congressional Office of Technology Assessment should develop an annual review of advances in technology for surgical implantation of artificial devices, with recommendations for altering Medicare payments to reflect these advances.

(6) The Senate should add its approval to House-passed legislation that will help restore the Medicare patient's confidence in the specialist performing his or her cataract surgery.

I. SECOND OPINION

Ethical practitioners have always urged their prospective surgical patients to seek a second, independent, medical opinion on the need for a particular surgical procedure. Not only is this in the patient's best interest, but in our litigious society it is to the surgeon's own interest as well. We are therefore pleased to see this provision mandated for all Medicare patients, in legislation reported by the House Energy and Commerce Committee (H.R. 3101, section 106); our only concern with the wording is that it must sufficiently stress the need for a truly independent second opinion, based on the patient's choice rather than the surgeon's referral. The new "Second Surgical Opinion Program" sponsored by the Department of Health and Human Services, offers a toll-free number (800-638-6833) to refer the caller to accredited surgeons in the caller's area with expertise in the special area of surgery contemplated.

II. ASSISTANT SURGEON

The above-mentioned pending legislation, as well as the Deficit Reduction bill reported by the House Ways and Means Committee (H.R. 3128, Section 147), both prohibit Medicare reimbursement for an assistant surgeon in routine cataract surgery, where the patient's pre-op condition reflects no complications likely to be exacerbated by the surgery. In addition, the June 7, 1985 report of the Inspector General of the Department of Health and Human Services documents the widely varying charges to Medicare for this service, with the conclusion that "Although the ophthalmologists require assistance during cataract surgery, such assistance is frequently provided by a surgical technician and/or operating room nurse." Because of greatly improved surgical techniques which have reduced actual operating time from 3 hours to less than 30 minutes, we agree with the Inspector General's recommendation to "exclude the services of an assistant surgeon from Medicare coverage for routine cataract surgery," and with his additional recommendation "to provide coverage for an assistant surgeon where special medical conditions exist." Such conditions, of course, can be identified more easily by the availability of a second opinion as to the need for such surgery.

III. REPLACEMENT (PROSTHETIC) LENSES FOR THE CATARACT PATIENT

All the references cited above, plus the findings of the January 10, 1985 report of the U.S. General Accounting Office (GAO) stress the need for uniformity in Medicare payments for a replacement lens provided the cataract surgery patient. The current wide disparity in lens costs charged to Medicare is documented in the Inspector General's report dealing mainly with surgically implanted intraocular lenses (IOL's); while the GAO report deals mainly with contact lenses or cataract glasses, equally subject to overcharge or abuse. In one instance cited by GAO testimony before the House Ways and Means Subcommittee on Health, on August 1, 1985, "one [Medicare] carrier paid a physician for 40 lenses in 20 months for one Medicare beneficiary." We are pleased to note that proposed limitations on reimbursement for prosthetic lens were published by HHS in the August 16 Federal Register.

We agree with all these authorities that costs for replacement lenses, whether IOL's, contact, or eyeglasses, should be separately identified in bills presented to Medicare. Further, we think the rate of additional replacements should be subject to medical justification by the prescribing ophthalmologist, with strict HHS scrutiny mandated. We feel the replacement rate recommended by GAO is "inherently reasonable"; it is also more generous than the rate recommended by the American academy of Ophthalmology (AAO) which perhaps has reacted hastily to the nationwide publicity on this issue. In an evident effort to distance itself from the target of this publicity, the American Medical Association has issued a policy statement emphasizing that a physician is not a commercial enterprise and "should not profit from the resale of products or from the work of others." Regrettably, because the AMA or AAO have not seen fit to enforce their own standards of ethics, remedial legislation is necessary.

IV. OUTPATIENT CATARACT SURGERY REIMBURSEMENT

Before 1981, cataract patients' surgery was almost always performed in-hospital, requiring a three-day stay with the patient immobilized. However, the last four years have seen a revolution in cataract surgery techniques, whereby most patients now do not need to be hospitalized at all. Today, 90 percent of all cataract surgery involves the implantation of intraocular lens; and, with greatly expedited surgical extraction of the natural clouded lens, the whole surgical procedure can be accomplished under local anaesthetic, in an outpatient setting, in less than an hour. The total patient time required, including pre-op and post-op, can be less than 3 hours. Naturally, the elderly patient would prefer this simpler, non-incapacitating procedure. Consequently, between 850,000 and 900,000 Americans, most of them elderly, will have had a cataract removed this year, with that number expected to top 1,000,000 by next year. As the Senate Appropriations Committee has stated in S. Rpt. 98-544;

"Most of the major eye problems that we face today in this country are aging-related. In the next 50 years there will be a 100-percent increase in the size of the American population over age 55 and a 150-percent increase in the number of those over 85."

Keeping in mind these demographic projections, the Committee's report commends NIH's prestigious National Eye Institute for pioneering research in senile cataract and other unhappy conmmitants of aging.

While this research was going foward, Congress enacted and the Secretary of HHS implemented a new method of health costs controls (the Prospective Payment System) applied to Medicare in late 1983. These PPS controls applied only to in-hospital Medicare patients, however. As a result, in the words of a Congressional witness at the August 1, Ways and Means hearings:

"Improved cataract surgical technique and hospital cost containment have contributed largely to a shift from the hospital to an outpatient setting . . . One would think that savings would accrue to the Medicare Program by eliminating hospital stays and the attendant services which accompany the stay. This has not been the case."

With the last sentence acknowledged as something of a masterpiece of understatement, its author, Representative Claude Pepper, adds:

"We found that roughly half of the nation's $3.5 billion annual bill for cataract surgery is lost to fraud, waste, and abuse. Losses to the Medicare program alone will total over $1.5 billions this year."

To apply controls only to a part of a system, of course, is to invite exploitation of the uncontrolled part. In order to remedy the situation, Representative Pepper's bill, H.R. 3061, would "cap" outpatient cataract surgery reimbursement by Medicare, by limiting the amount paid at either the hospital DRG-39 rate or the ambulatory surgical center payment—whichever is lower. In the Senate, an even broader approach has been taken by Senator David Durenberger's bill, S. 1489, which would impose a Prospective Payment System on all outpatient surgery reimbursed by Medicare. While we enthusiastically commend the thrust of H.R. 3061, a review of the July 31, 1985 HHS report on the nation's annual health care costs persuades us that the broader approach is necessary. The HHS report documents a dramatic drop in hospital—based health care costs since imposition of Medicare's Propsective Payment System; but at 15 percent increase in dentists' bills (dental surgery is reimbursable by Medicare), a 10.2 percent increase in doctors' charges, and a 9.4 percent increase in prescription drugs.

V. ANNUAL REVIEW OF SURGICAL TECHNOLOGY ADVANCES

Following his committee's two-year investigation into cataract surgery practices, Representative Pepper introduced not only H.R. 3061 as outlined above, but also another bill, H.R. 3119, so that Congress would be better able, on an annual basis, to determine reasonable charges. In his introductory remarks, Mr. Pepper observed:

"This would keep Medicare payments in line with rapidly changing technology and skills. Having no formal mechanism to do this has resulted in unreasonable and wasteful reimbursement. For example, the fee paid to [cataract surgery] physicians is now around $1,200. This rate was established prior to 1981 when the procedure took 3 hours. Now a surgeon can perform the same surgery in 20 to 30 minutes, but Medicare has not altered payments."

Although pending House bills on deficit reduction provide varying mechanisms for technical review, only H.R. 3119 requires the Congressional Office of Technology Assessment to conduct such a review, independently from possible Departmental pressures. We feel such independence guarantees an objective assessment, with the mandated annual review a long-overdue component of reasonable cost control.

VI. RESTORING PATIENT CONFIDENCE

The investigation cited above have offered incontrovertible proof of what may be fairly described as the biggest mass exploitation of blind people in American history. As a result, the prospective cataract surgery patient, having been exposed to the national publicity resulting from the investigatons, is bound to suffer from uncertainty and a loss of confidence, not wanting to be a party to exploitation of Medicare's resources. To restore patient confidence in the integrity of medical care, we therefore advocate Senate concurrence in a House-passed bill, H.R. 1868, (the Medicare-Medicaid Patient Protecton bill) which will authorize the Inspector General of HHS to eliminate from the Medicare system the estimated 20 percent of cataract surgeons who have been indentified as participating in unethical practices. Although our main concern is restoring patient confidence in quality care, we also feel that the remaining 80 percent of the nation's 13,508 ophthalmologists would welcome this means of vindication of their professional integrity.

SUMMARY

Since its founding in 1921, the American Foundation for the Blind has recognized and encouraged the desire of all our visually handicapped citizens to join and participate in the mainstream of American society. Blind and visually handicapped citizens have perhaps a special insight into the need for a healthy national economy, since ever-increasing deficits, translated into inflated costs, invariably inflict the greatest harm on those least able to afford it—the disabled and the elderly living on fixed incomes. Our research has shown that by far the greatest number of blind and visually impaired are found in the segment of our population that is both elderly and subsisting mainly on social security payments. If inflated copayments for needed cataract surgery are required of this segment, they may simply not have the resources, with the unnecessary and unpalatable alternatives of institutionalization. With adequate cost controls, both our visually handicapped citizen and our country will benefit.

EXCERPTS FROM SENATE FINANCE PRESS RELEASE, SEPTEMBER 20, 1985

Eight. *Prospective Payment for Ambulatory Surgery.*—Prospective payment rates for ambulatory surgery performed in hospital outpatient departments or ambulatory surgical centers would be established. The payment rates would be the same for both settings.

Nine. *Payments for Assistants at Surgery.*—Unless medically necessary, Medicare would no longer pay for assistants at routine cataract surgery.

Ten. *Audit and Medical Claims Review.*—The funding of audits and medical reviews would be increased.

Eleven. *Reimbursement for Prosthetic Lenses.*—Payments for the replacement of eyeglasses or contact lenses for persons who have had cataract surgery would be limited unless the patient's condition changed or the lenses were no longer usable.

[Whereupon, at 3:10 o'clock, the task force adjourned.]

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